South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

P.O. Box 100191, Columbia, SC 29202-3191

Medicare Advantage Individual Enrollment Request Form

To Enroll in Medicare Blue℠ or Medicare Blue℠ Plus, Please Provide the Following Information:

Please check which plan you want to enroll in:

____ Medicare Blue $36.00 per month ____ Medicare Blue Plus $108.00 per month

LAST name:	FIRST name:	Middle Initial	☐Mr. ☐Mrs. ☐Ms.

Birth Date	Sex:	Social Security Number:	Home Phone Number:
(__ __/__ __/__ __ __ __) (M M/D D/Y Y Y Y)	☐ M ☐ F	*(providing this information is optional)*	( )

Permanent Residence Street Address:

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency contact:__Relationship to You:_____

Phone Number:_____ **E-mail Address:**_____

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
  – OR –
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare **Health Insurance**

SAMPLE ONLY

Name:_____

Medicare Claim Number Sex_____

__ __ __ - __ __ - __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium

You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill.

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _

Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Savings

☐ Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration Date: _ _ / _ _ _ _ (MM/YYYY)

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing that you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or belong to a State pharmaceutical assistance program.

   Will you have other <u>prescription</u> drug coverage in addition to Medicare Blue or Medicare Blue Plus?
   ☐ Yes ☐ No

   If "yes," please list your other coverage and your identification (ID) numbers for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:
_____	_____	_____

3. Are you a resident in a long-term-care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution:_____

Address (number and street) & Phone Number of Institution:_____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes," please provide your Medicaid number:_____

5. Do you, or your spouse, work? ☐ Yes ☐ No

Please tell us the name of your Primary Care Physician (PCP):

Physician Name_____ Phone Number _____

Please tell us the name of your preferred hospital, clinic or health center:

Name _____Phone Number _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish

☐ Large print or audio tapes

Please contact Medicare Blue or Medicare Blue Plus at 1-800-605-3256 (TTY users should call 1-888-300-7215) if you need information in another format or language than what is shown above. From November 15, 2008 through March 1, 2009, Customer Service representatives will be available to answer your calls from 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week. Beginning March 2, 2009, your calls will be handled by our automated phone system after 8:00 p.m. and on Saturdays, Sundays and holidays.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Medicare Blue or Medicare Blue Plus could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Medicare Blue or Medicare Blue Plus may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office shown in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

Medicare Blue or Medicare Blue Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (example: November 15 – December 31 of every year, or under certain special circumstances.

Medicare Blue and Medicare Blue Plus serve a specific service area. If I move out of the area that Medicare Blue or Medicare Blue Plus serves, I need to notify the plan so that I may disenroll and find a new plan in my new area. Once I am a member of Medicare Blue or Medicare Blue Plus, I have the right to appeal plan decisions about payment or services, if I disagree. I will read the "Evidence of Coverage" from Medicare Blue or Medicare Blue Plus when I receive it, to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that beginning on the date Medicare Blue or Medicare Blue Plus coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Medicare Blue or Medicare Blue Plus provides reimbursement for all covered benefits, even if received out of network. Services authorized by Medicare Blue or Medicare Blue Plus and other services contained in my Medicare Blue or Medicare Blue Plus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE BLUE OR MEDICARE BLUE PLUS WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Medicare Blue or Medicare Blue Plus, he/she may be compensated based on my enrollment in Medicare Blue or Medicare Blue Plus.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans, as is necessary for treatment, payment and health care operations. I also acknowledge that Medicare Blue or Medicare Blue Plus will release my information, including my prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Medicare Blue or Medicare Blue Plus or by Medicare.

Your Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: **Name**:_____ **Address**:_____ **Phone Number**: (___) _____-_____ **Relationship to Enrollee**:_____	

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID#:_____
Effective Date of Coverage:_____
ICEP/IEP:_____ OEP:_____ AEP:_____ SEP (type):_____ Not Eligible:_____

Agent Name *(print)*:_____	Agent Number:_____
Agent Signature:_____	Date:_____

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you may join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan.
- ☐ I recently moved and this plan is a new option for me.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- ☐ I receive extra help paying for Medicare prescription drug coverage.
- ☐ I am no longer eligible for extra help paying for my Medicare prescription drugs.
- ☐ I live in, or recently moved out of, a Long-Term-Care Facility (for example, a nursing home).
- ☐ I recently "left" a PACE program.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- ☐ I am leaving employer or union coverage.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S.
- ☐ None of these statements applies to me.*

*Please contact Medicare Blue or Medicare Blue Plus at 1-800-605-3256 (TTY users should call 1-888-300-7215) to see if you are eligible to enroll. From November 15, 2008 through March 1, 2009, Customer Service representatives will be available to answer your calls from 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week. Beginning March 2, 2009, your calls will be handled by our automated phone system after 8:00 p.m. and on Saturdays, Sundays and holidays.