

# 2012 Individual Enrollment Request Form

## Blue Shield 65 Plus (HMO) and Blue Shield 65 Plus Choice Plan (HMO)

Please contact Blue Shield of California if you need information in another language or format (Braille).

To enroll in Blue Shield 65 Plus<sup>SM</sup> or Blue Shield 65 Plus Choice Plan<sup>SM</sup>, please provide the following information:

Please check which plan you want to enroll in, based on where you live:

- Los Angeles\*/Orange counties (\$0 per month)       Riverside\* County (\$0 per month)  
 San Bernardino\* County (\$0 per month)       Choice Plan\* (\$0 per month)

\*See your Summary of Benefits for covered ZIP codes.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	First name	Middle initial
Birth date ( ___ / ___ / ___ - ___ ) ( MM / DD / Y Y Y Y )	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number (     )	
<b>Permanent residence street address (no P.O. boxes)</b>			
Street	City	State	ZIP code
<b>Mailing address (only if different from your permanent residence address)</b>			
Street	P.O. Box	City	State ZIP code
Emergency contact	Relationship to you	Phone number (     )	

E-mail address \_\_\_\_\_

- I am willing to receive required plan materials via e-mail (i.e., the Annual Notice of Change and plan newsletter) in place of mailed printed copies.  
 I am willing to receive non-required materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.


You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

### 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 Social Security or the Railroad Retirement Board.

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

<b>MEDICARE</b>  <b>HEALTH INSURANCE</b>	
SAMPLE ONLY	
Name:	_____
Medicare Claim Number	Sex _____
_____ - _____ - _____	
Is Entitled To	Effective Date
<b>HOSPITAL (Part A)</b>	_____
<b>MEDICAL (Part B)</b>	_____

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**If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.**

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

Please select a late enrollment penalty payment option:

- Receive a monthly statement and pay by mail.
- Automatic check draft (ACH) from your bank account each month. Please fill out the Blue Shield Easy\$Pay<sup>SM</sup> form. If you do not have a copy of the form, please call us and we will send you one.
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay Blue Shield the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp). 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 doesn't cover.

## **Please read and answer these important questions**

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

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

- 2.** Some individuals may have other drug coverage, including other private insurance, coverage through their former employer/union, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan?

- Yes  No

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

### **Prescription drug coverage**

Name of other coverage

ID No. for this coverage

Group No.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Medical coverage**

Name of other coverage

ID No. for this coverage

Group No.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 and phone number of Institution (number and street) \_\_\_\_\_

4. Are you enrolled in your State Medicaid program (Medi-Cal)?  Yes  No

If yes, please provide your Medicaid (Medi-Cal) number \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

### Primary Care Physician

Please choose the name of a Primary Care Physician.

Your physician choice \_\_\_\_\_

Physician ID No. \_\_\_\_\_ Current patient  Yes  No

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

Please contact Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan at **(800) 776-4466**

[TTY users should call (800) 794-1099] if you need information in a format or language other than what is listed above. Our office hours are 7 a.m. to 8 p.m., seven days a week.



### Please read this important information

**If you currently have health coverage from an employer or union, joining Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any 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:** Blue Shield 65 Plus and Blue Shield 65 Plus Choice Plan are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in 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: October 15 - December 7 of every year), or under certain special circumstances.

Blue Shield 65 Plus and Blue Shield 65 Plus Choice Plan serve a specific service area. If I move out of the area that Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan serve, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan coverage begins, I must get all of my health care from Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan and other services contained in my Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS OR BLUE SHIELD 65 PLUS CHOICE PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield, he/she may be paid based on my enrollment in Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan.

**Release of information:** By joining this Medicare health plan, I acknowledge that Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which 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 live) 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 from Medicare.

\_\_\_\_\_  
Signature Today's date

**If you are the legally authorized representative (i.e., power of attorney or legal guardian – see description above), you must sign above and provide the following information:**

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone number ( \_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Relationship to enrollee \_\_\_\_\_

**Producer information:**

Producer name \_\_\_\_\_ (Please print name) Producer ID No. \_\_\_\_\_

Producer phone number ( \_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_

Producer signature \_\_\_\_\_

Date application received by producer: \_\_\_\_\_

With my signature, I hereby certify that I have read and understand the CMS Medicare Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete pre-sale kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

**Office use only:**

Name of staff member (if assisted enrollment) \_\_\_\_\_ (Please print name)

Plan ID No. \_\_\_\_\_ Effective date of coverage \_\_\_\_\_ ICEP/IEP \_\_\_\_\_

AEP \_\_\_\_\_ SEP (type) \_\_\_\_\_ Not eligible \_\_\_\_\_ NIPR# \_\_\_\_\_