Thank you for choosing BlueCHiP for Medicare

Please tear off this card and insert between the pages when completing this enrollment form. Thank you.

BlueCHiP for Medicare
2018 Individual Enrollment Request Form

Blue Cross Blue Shield of Rhode Island

Please contact BlueCHiP for Medicare if you need information in another language or alternate format (large print*).

Section 1 - Please Check Which Plan You Want to Enroll In

Medical and Prescription Drug Plans

☐ BlueCHiP for Medicare Advance (HMO): $0 per month

☐ BlueCHiP for Medicare Standard with Drugs (HMO): $58 per month

☐ BlueCHiP for Medicare Extra (HMO-POS): $97 per month

☐ BlueCHiP for Medicare Plus (HMO): $168 per month

☐ BlueCHiP for Medicare Preferred (HMO-POS): $257 per month

☐ BlueCHiP for Medicare Value (HMO-POS): $23 per month; $33 per month for Newport County Only
(Newport County Zip Codes: 02801, 02835, 02837, 02840, 02841, 02842, 02871, 02878)

Optional Supplemental Dental Rider

☐ BlueCHiP for Medicare Dental Rider: $22.70 per month

Medical Plan Only

☐ BlueCHiP for Medicare Core (HMO): $0 per month

Section 2 - Please Provide Personal Information (Please Print)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date _____/_____/_____ MM / DD / YYYY

Sex ☐ M ☐ F

Home Phone Number ( )

Cell Phone Number ( )

Permanent Residence Street Address (P.O. Box is not allowed)

City | State | ZIP Code

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

City | State | ZIP Code

Billing Address (only if different from your Mailing Address)

City | State | ZIP Code

Email Address

Emergency Contact _____

Phone Number (_____)_____ Relationship to You _____

If you would like to select a Designee/personal representative, please complete the Designee Form, which you will receive in your Welcome Kit.

*Not all materials may be available in alternate formats.

Section 3 - Please Provide the Name of Your Primary Care Physician (PCP)*

Last Name	First Name	
Address		
City	State	ZIP Code
Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No	Phone ( )	

*For all BlueCHiP for Medicare plans, you're required to select a primary care physician (PCP). If you're enrolled in our BlueCHiP for Medicare Advance plan, you must select a PCP from the BlueCHiP for Medicare Advance PCP network. If you do not select a PCP, BCBSRI will assign one for you.

Section 4 - Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  -OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

Section 5 - Please Read and Answer These Important Questions

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, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to BlueCHiP for Medicare? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) 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 of Institution:_____
   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 check one of the boxes below if you would prefer us to send you information in: ☐ Spanish ☐ Large print

To request future materials in Spanish or in large print, please contact the Medicare Concierge Team at 1-800-267-0439. (TTY users should call 711). The Medicare Concierge Team is available October 1 - February 14, seven days a week, 8 a.m. to 8 p.m.; February 15 - September 30, Monday through Friday, 8 a.m. to 8 p.m.; Saturday & Sunday 8 a.m. to 12 p.m. An automated answering system is available outside of these hours.

Section 6 – Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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 left a PACE program on _____/_____/_____. (insert effective date)
☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on _____/_____/_____. (insert effective date)	☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____/_____/_____. (insert effective date)
☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____/_____/_____. (insert effective date)	☐ I am leaving employer or union coverage on _____/_____/_____. (insert effective date)
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	☐ I belong to a pharmacy assistance program provided by my state.
☐ I get Extra Help paying for Medicare prescription drug coverage.	☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on _____/_____/_____. (insert effective date)	☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____/_____/_____. (insert effective date)
☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on _____/_____/_____. (insert effective date)	☐ Annual enrollment period (AEP) - October 15 through December 7 enrollments, effective January 1.

If none of these statements apply to you or you're not sure, please contact a Medicare sales representative at 1-800-505-2583 (TTY users should call 711) to see if you are eligible to enroll. Hours are Monday through Friday, 8 a.m. to 8 p.m. (open seven days a week, 8:00 a.m. to 8:00 p.m., from October 1 – February 14). You can use our automated answering system outside of these hours.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining BlueCHiP for Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueCHiP for Medicare. 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.

Section 7 – Paying Your Plan Premium

If you choose BlueCHiP for Medicare Advance (HMO) and 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. You can pay by mail or Electronic Funds Transfer (EFT) each month or quarterly. You can also choose to pay your premium by automatic deduction from your Social Security benefit check or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. 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 BlueCHiP for Medicare for the Part D-IRMAA.

For all other plans, you can pay your monthly plan premium (*including any late enrollment penalty that you currently have or may owe*) by mail each month or quarterly or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check or Railroad Retirement Board (RRB) benefit check each month. 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 BlueCHiP for Medicare for 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 co-insurance. 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.

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.

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

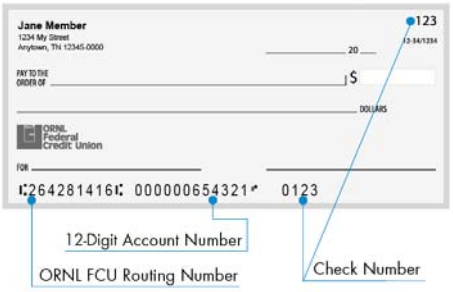
☐ Option 1 - Electronic Funds Transfer (EFT) from your bank account each month.

1. Fill out the information below:
   Account Holder Name: _____

   Bank Routing Number: _____

   Bank Account Number: _____

   Account Type: ☐ Checking ☐ Savings



2. Attach a voided check to this form. Write "VOID" on the blank check from the account you would like the EFT payments withdrawn from. Do NOT send a deposit slip, blank check, or canceled check.

☐ Option 2 - Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security or 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.)

☐ Option 3 - Direct bill

Please select a premium payment option: ☐ Receive a bill monthly ☐ Receive a bill quarterly

Section 8 – Please Read and Sign Below

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

BlueCHiP for Medicare is a Medicare Advantage plan and *has a contract with the Federal government*. I will need to keep my Medicare 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

BlueCHiP for Medicare serves a specific service area. If I move out of the area that BlueCHiP for Medicare serves, 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 BlueCHiP for Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueCHiP for Medicare 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.

To obtain in-network coverage, I understand that beginning on the date my BlueCHiP for Medicare coverage begins, all services except for emergency or urgently needed services or out-of-area dialysis services must be obtained from providers participating in the network specific to the plan I have chosen. Services authorized by BlueCHiP for Medicare and other services contained in my BlueCHiP for Medicare Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUECHIP FOR MEDICARE 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 BlueCHiP for Medicare, he/she may be paid based on my enrollment in BlueCHiP for Medicare.

Release of Information: By joining this Medicare health plan, I acknowledge that BlueCHiP for Medicare will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that BlueCHiP for Medicare 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 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 by BlueCHiP for Medicare or from Medicare.

Signature: _____ Today's Date: _____

If you are the enrollee, please ensure you have signed above.
If you are signing on behalf of the enrollee, please sign above AND complete the authorized representative section below.

Last Name	First Name	
Address		
City	State	ZIP Code
Relationship to Enrollee	Phone Number ( )	

Congratulations! You have completed your BlueCHiP for Medicare Enrollment Request Form. Please ensure you have signed where indicated and return all 7 pages. Please keep the yellow copy for your own records. Thank you.

Internal Use Only – To Be Completed by Agent

☐ AEP	☐ ICEP	☐ IEP
☐ SEP		☐ OEPI (Institutionalized)
☐ Other SEP (SEP Reason): _____		

Sales Agent Signature (if assisted in enrollment)	Agent Received Date
Print Sales Agent Name	Broker ID#
Plan ID #	Effective Date of Coverage _____/_____/_____. MM / DD / YYYY