

Thank you for choosing a
Blue Cross & Blue Shield of Rhode Island
Medicare Advantage plan



2027 Individual Medicare Enrollment Request Form

Section 1 – Select the Plan You Want to Enroll In	
Medical and Prescription Drug Plans	☐ BlueCHiP for Medicare Essential (HMO-POS): \$0 per month
	☐ BlueCHiP for Medicare Enhanced (HMO-POS): \$39 per month
	☐ BlueCHiP for Medicare Extra (HMO-POS): \$159 per month
Medical Plan Only	☐ BlueCHiP for Medicare Core (HMO) \$0 per month

Section 2 – Personal Information (Please Print)		
Last Name	First Name	Middle Initial (optional)
Birthdate / / (MM / DD / YYYY)	Sex ☐ M ☐ F	
Phone Number ()	Alternate Phone (optional) ()	
Medicare Number		
Permanent Residence Street Address (P.O. Box is not allowed)		
City	State	ZIP Code
Mailing Address (only if different from your permanent address — P.O. Box is allowed)		
City	State	ZIP Code
Email Address		

Section 3 – Name of Your Primary Care Provider (PCP)*		
Last Name	First Name	
Address		
City	State	ZIP Code
Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No		Phone ()

*For all BlueCHiP for Medicare plans, you're required to select a primary care provider (PCP). If you do not select a PCP, Blue Cross & Blue Shield of Rhode Island (BCBSRI) may assign one for you.

Section 4 – Please Read and Answer These Important Questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Do you have other drug coverage? ☐ Yes ☐ No

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

Name of Other Coverage: _____

ID Number for this Coverage: _____

Group Number for this Coverage: _____

2. 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: _____

We’re asking for this **optional** information to help us better understand our members’ needs. Your responses or choice not to respond will not affect your benefits, coverage, or costs.

3. We try to accommodate a member’s preferred language to receive BCBSRI correspondence when possible.

Do you have a preferred language other than English?

☐ Spanish

☐ Portuguese

4. Select one if you want us to send you information in an accessible format.

☐ Large Print

☐ Audio CD

☐ Braille

☐ Data CD

5. Do you work?

☐ Yes

☐ No

Does your spouse work?

☐ Yes

☐ No

6. Would you like to receive the following materials electronically as they become available?

☐ Plan material (e.g. Medical Explanation of Benefits, Annual Notice of Change, Premium Invoice)

Email Address: _____

Cell phone (text communications only): _____

Please contact our Medicare Concierge team at 1-800-267-0439 if you need information in an accessible format or language other than what is listed above. The Medicare Concierge team is available October 1 to March 31, seven days a week, 8:00 a.m. to 8:00 p.m.; April 1 to September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday 8:00 a.m. to noon. An automated answering system is available outside of these hours. TTY users should call 711.

Section 5 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or electronic funds transfer (EFT) each month or quarterly. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Blue Cross & Blue Shield of Rhode Island the Part D-IRMAA.

☐ **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

The diagram shows a check from Jane Member at ORNL Federal Credit Union. It includes fields for the payee, amount, and date. A 12-digit account number (123456789012) and the ORNL FCU Routing Number (000000654321) are highlighted with a blue box and labeled '12-Digit Account Number' and 'ORNL FCU Routing Number'. The check number (0123) is also highlighted and labeled 'Check Number'.

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

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 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.

- ☐ Annual enrollment period (AEP) - October 15 through December 7 enrollments, effective January 1, 2027.
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I am leaving employer or union coverage on (insert date) ____/____/____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ____/____/____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert 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 date) ____/____/____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____/____/____.
- ☐ I recently was released from incarceration. I was released on (insert date) ____/____/____.
- ☐ I recently received notification of my retroactive Medicare entitlement on (insert date) ____/____/____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____/____/____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____/____/____.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) ____/____/____.
- ☐ I recently left a PACE program on (insert date) ____/____/____.
- ☐ I'm in a qualified State Pharmaceutical Assistance program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert 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 date) ____/____/____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ Other _____

If none of these statements apply to you, or you're not sure, please contact our Blue Cross & Blue Shield of Rhode Island Sales team at **1-800-505-2583** (TTY users should call 711) to see if you are eligible to enroll. Seven days a week from October 1 to March 31, 8:00 a.m. to 8:00 p.m., October 1 to March 31. From April 1 to September 30, you can call Monday through Friday, from 8:00 a.m. to 8:00 p.m. You can use our automated answering system outside of these hours.

Section 7 – IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueCHiP for Medicare
- By joining this Medicare Advantage plan, I acknowledge that BlueCHiP for Medicare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my BlueCHiP for Medicare coverage begins, I must get all of my medical and prescription drug benefits from BlueCHiP for Medicare. Benefits and services provided by BlueCHiP for Medicare and contained in my BlueCHiP for Medicare “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueCHiP for Medicare will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Enrollee Signature: X **Today's Date:** _____

If you're the authorized representative, sign above and complete fields below:

Last Name	First Name
Address	
Relationship to Enrollee	Phone Number ()

Mailing Address for completed forms:

Blue Cross Blue Shield of Rhode Island Membership Department – 00083
500 Exchange Street
Providence, RI 02903-9743

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form

Signature (if assisted in enrollment)		Agent Received Date
Print Name	Broker ID#	Broker/Agent National Producer Number (NPN)
Effective Date of Coverage ____ / ____ / ____ MM / DD / YYYY		Relationship to Enrollee
☐ AEP	☐ ICEP	☐ OEP
☐ SEP	☐ IEP	☐ OEPI (Institutionalized)



500 Exchange Street • Providence, RI 02903-2699 • www.bcbsri.com/medicare
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