

Thank you for choosing
a Medicare Advantage plan
that offers extra support



2027 Individual Medicare Enrollment Request Form

Section 1 – Select the Plan You Want to Enroll In

Medical and Prescription Drug Plans	☐ BlueCHIP for Medicare Access (HMO-POS): \$31.30 per month
	☐ BlueRI for Duals (HMO D-SNP): \$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) ()	
Permanent Residence Street Address (P.O. Box is not allowed unless you're experiencing homelessness)		
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 ()

*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 Provide Your Medicare Insurance Information

To confirm your eligibility for Medicare coverage, the information below is required to process this form.

Please use 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 – BlueRI for Duals (HMO D-SNP) Applicants Only

Please use your Rhode Island **Medicaid** “Anchor” Card to fill out this section. For assistance, call the BlueRI for Duals (HMO D-SNP) Sales team at 1-855-430-9293.

Name (as it appears on your Medicaid card):

Medicaid ID Number (MID): _____

- Social Security Number (required for Medicaid verification): ____ - ____ - ____ - ____ - ____ - ____
- Are you experiencing housing insecurity or homelessness? ☐ Yes ☐ No

Section 6 – 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: _____

Cellphone (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 7 – 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 8 – Paying Your Plan Premium

Normally, you are not required to pay a premium. However, if you lose your Part D Low Income Subsidy (or “Extra Help”) or Medicaid subsidy, you may be responsible for paying a premium. In this instance, how would you like to pay?

☐ **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, ORNL Federal Credit Union. Callouts identify the 12-Digit Account Number (123456789012), the ORNL FCU Routing Number (000000654321), and the Check Number (123).

☐ **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 9 – IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueRI for Duals (HMO D-SNP) or BlueCHiP for Medicare Access (HMO-POS).
- By joining this Medicare Advantage plan, I acknowledge that BlueRI for Duals (HMO D-SNP) or BlueCHiP for Medicare Access (HMO-POS) 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 BlueRI for Duals (HMO D-SNP) or BlueCHiP for Medicare Access (HMO-POS) coverage begins, I must get Medicare benefits from BlueRI for Duals (HMO D-SNP) or BlueCHiP for Medicare Access (HMO-POS). Covered benefits and services provided by BlueRI for Duals (HMO D-SNP) or BlueCHiP for Medicare Access (HMO-POS) are contained in my “Evidence of Coverage” document (also known as a member contract or subscriber agreement). Neither Medicare nor BlueRI for Duals (HMO D-SNP) or BlueCHiP for Medicare Access (HMO-POS) 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 form means that I have read and understand the contents of this form. 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 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.

If You're the Authorized Representative, Sign Above and Fill Out These Fields Below:

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

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.

Mailing Address for completed forms:

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

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)		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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