

BlueCHIP for Medicare 2015 Individual Enrollment Request Form



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

To Enroll in BlueCHIP for Medicare, Please Provide the Following Information:			
Please check which plan you want to enroll in:			
<input type="checkbox"/> BlueCHIP for Medicare Core (HMO) \$0 per month	<input type="checkbox"/> BlueCHIP for Medicare Standard with Drugs (HMO) \$44 per month		
<input type="checkbox"/> BlueCHIP for Medicare Select** (HMO) \$0 per month	<input type="checkbox"/> BlueCHIP for Medicare Extra (HMO-POS) \$84 per month		
<input type="checkbox"/> BlueCHIP for Medicare Value (HMO-POS) \$0 per month	<input type="checkbox"/> BlueCHIP for Medicare Plus (HMO) \$166 per month		
<input type="checkbox"/> BlueCHIP for Medicare Dental \$38.90 per month	<input type="checkbox"/> BlueCHIP for Medicare Preferred (HMO-POS) \$251 per month		
Please Print Information Below:			
LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (____/____/____) M M / D D / Y Y Y Y	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate 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 Address):			
Street Address:	City:	State:	ZIP Code:
Billing Address (only if different from your Mailing Address):			
Street Address:	City:	State:	ZIP Code:
Emergency Contact: _____			
Phone Number: _____ Relationship to You: _____			
Is your emergency contact also your designee/personal representative? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If not, please indicate your designee [†] below:			
Name of Designee: _____			
Phone Number: _____ Relationship to You: _____			
Email Address:			
How did you hear about us?			

*Not all materials may be available in large print.

**Must receive care within Select network of providers.

[†]Please note that if you choose to select a designee, you are still required to complete our Designee Form, which you will receive in your Welcome Kit or by calling the BlueCHIP for Medicare Concierge Team at 1-800-267-0439.


Initials: _____ **Today's Date:** _____

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.

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

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 choose the name of a Primary Care Physician (PCP), clinic, or health center:

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 the BlueCHIP for Medicare Concierge Team at 1-800-267-0439. Our office hours are **October 1, 2014 – February 14, 2015**, seven days a week, 8:00 a.m. to 8:00 p.m.; **February 15, 2015 – September 30, 2015**, Monday to Friday, 8:00 a.m. to 8:00 p.m. TTY users should call 711.

Initials: _____ **Today's Date:** _____

Attestation of 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.

- | | |
|--|--|
| <input type="checkbox"/> I am new to Medicare. | <input type="checkbox"/> I recently left a PACE program on (insert date) _____ . |
| <input type="checkbox"/> 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) _____ . | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ . |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ . | <input type="checkbox"/> I am leaving employer or union coverage on (insert date) _____ . |
| <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state _____ . |
| <input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage. | <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. |
| <input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____ . | <input type="checkbox"/> 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) _____ . |
| <input type="checkbox"/> 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) _____ . | |

If none of these statements apply to you or you're not sure, please contact the BlueCHIP for Medicare Sales Department at **1-800-505-2583** (TTY users should call 711) to see if you are eligible to enroll. We are open **October 1, 2014 – February 14, 2015**, seven days a week, 8:00 a.m. to 8:00 p.m.; **February 15, 2015 – September 30, 2015**, Monday to Friday, 8:00 a.m. to 8:00 p.m.



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.

Initials: _____

Today's Date: _____

Paying Your Plan Premium

If you have BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), or BlueCHiP for Medicare Value (HMO-POS): 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. 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 or 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 or 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.

Please select a premium payment option:

- Get a MONTHLY bill
- Get a QUARTERLY bill
- Electronic funds transfer (EFT) from your bank account each month. If you are interested in the EFT payment option, please contact us at the phone number listed on the previous page.
- 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.)

Initials: _____

Today's Date: _____

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.

I understand that beginning on the date BlueCHIP for Medicare coverage begins, I must get all of my health care from BlueCHIP for Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BlueCHIP for Medicare and other services contained in my BlueCHIP for Medicare Evidence of Coverage document (also known as a 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 health care operations. I also acknowledge that BlueCHIP for Medicare 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 by BlueCHIP for Medicare or from Medicare.

Signature:

Today's Date:



Please return all 6 pages

Initials: _____

Today's Date: _____

If you are the authorized representative, you must <i>sign below and</i> provide the following information:	
Name:	Phone Number: () _____ - _____
Address:	
Relationship to Enrollee:	
Signature:	Today's Date:
Office Use Only:	
Name of staff member/agent/broker (if assisted in enrollment):	Broker ID#:
Plan ID #:	Effective Date of Coverage:
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____	

Please keep yellow copy for your records.

Initials: _____ **Today's Date:** _____



500 Exchange Street • Providence, RI 02903-2699
Blue Cross & Blue Shield of Rhode Island is an independent licensee
of the Blue Cross and Blue Shield Association.