

ENROLLMENT FORM

INFORMATION TO DETERMINE ENROLLMENT PERIODS:

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. However, there are exceptions that may allow you to enroll in Blue Medicare PPO outside of these periods. Please read the following statements and check the box to the left of the statement(s) that apply to you.

- I am new to Medicare.
- I recently moved outside the service area for my current plan.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help or I am no longer eligible for extra help paying for Medicare prescription drug coverage.
- I live in a Long Term Care Facility (for example, a nursing home or long term care facility).
- I just moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my coverage that is creditable prescription drug coverage (as good as Medicare's).
- I am either losing coverage I had from an employer or leaving employer coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- I'm enrolled in the Original Medicare Plan.

If none of these statements applies to you, or if you are not sure, please contact us at our Customer Service department at 1-866-308-4781, 8 a.m. – 8 p.m., local time, 7 days a week, to see if you are eligible to enroll. For the hearing or speech impaired, please call 1-800-538-0380.

To ensure timely processing of your enrollment and determine if your requested effective date can be accommodated, it is imperative we understand the date associated with the reason (e.g. date of move; date creditable coverage ends) checked above. Please insert that date here: / /

Requested effective date: / / (Please note that CMS enrollment guidelines may not allow for us to accommodate your requested date. Your enrollment confirmation letter will include your actual effective date.)



PLEASE READ THIS IMPORTANT INFORMATION:

If you currently have health coverage from an employer or union, joining Blue Medicare PPO could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue Medicare PPO may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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PLEASE READ AND SIGN BELOW:

By completing this enrollment application, I agree to the following: Blue Medicare PPO is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue Medicare PPO or by calling 1-800-MEDICARE. For the hearing or speech impaired, please call 1-877-486-2048, 24 hours a day, 7 days a week. Blue Medicare PPO serves a specific service area. If I move out of the Blue Medicare PPO service area, 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 Medicare PPO, 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 Medicare PPO when I receive it to know which rules I must follow in order to receive coverage with Blue Medicare PPO. I understand that Medicare beneficiaries are generally not 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 Medicare PPO coverage begins, I must get all of my health care from Blue Medicare PPO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Medicare PPO and other services contained in my Blue Medicare PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE MEDICARE PPO WILL PAY FOR THESE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Medicare PPO 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 behalf of the individual under the laws of the State where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. 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 Blue Medicare PPO or by Medicare.

Your Signature:

X

Today's Date:

/ /

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (____) _____ Relationship to Enrollee: _____

AGENT INFORMATION IF APPLICABLE: (PLEASE PRINT)

Note: This section should identify the agent OR agency to be compensated for this applicant.

Agent or Agency Name: _____

Agent Code: (i.e., Tax ID#): _____

Signature of Agent: _____ Date Signed: _____

Phone Number: _____ Agency Name: (if applicable) _____

The person that is discussing plan options with you is either employed by or contracted with Blue Medicare PPO. This person may be compensated based on your enrollment in Blue Medicare PPO.

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Blue Cross and Blue Shield of New Mexico refers to HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Advantage and Part D products under contract H3208 with the Centers for Medicare and Medicaid Services.