

# MedicareBluePPO<sup>SM</sup>

## ENROLLMENT FORM

- Medicare Blue PPO with prescription drugs  
\$57.50 a month
- Medicare Blue PPO Basic without prescription drugs  
\$22.40 a month

Requested Effective Date:

/  /

### To Enroll in Medicare Blue PPO<sup>SM</sup>, please provide the following information:

Last Name:   Mr.  Mrs.  Ms.

First Name:  Middle Initial:

Birth Date (MM/DD/YYYY):  -  -  Sex:  M  F

Social Security Number: (Optional field)  -  -

Home Phone Number:  -  -   
*Area Code*

Permanent Residence Street Address:

City:  County:  State:  ZIP Code:

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

City:  State:  ZIP Code:

Emergency Contact: (Optional field)

Emergency Contact Phone Number: (Optional field)  -  -   
*Area Code*

Relationship To You: (Optional field)

E-mail Address: (Optional field)

### 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Advantage plan.



SAMPLE ONLY

Name:

Medicare Claim Number  -  -  Sex

-   -

Is Entitled To  Effective Date

**HOSPITAL (Part A)**

**MEDICAL (Part B)**

# ENROLLMENT FORM

## Paying your plan premium:

You can pay your monthly plan premium by mail, by “Electronic Funds Transfer (EFT),” or by automatic deduction from your Social Security Check. 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 does not cover. If you don’t select a payment option, you will receive a bill each month.

**Please select a premium payment option:**

**Receive a bill**

**Electronic funds transfer (EFT) from your bank account each month. IMPORTANT:** Please attach a voided check from the account from which premium payments will be deducted. In addition, please include your first month’s premium when you return this application.

Account holder name: \_\_\_\_\_

Bank or financial institution: \_\_\_\_\_

Bank routing number:  Bank account number:

Signature of account holder: \_\_\_\_\_ Account type:  Checking  Savings

**Automatic deduction from your monthly SSA benefit check.** (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

## Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)?  YES  NO

If you answered “yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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 Medicare Blue PPO?  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 & Phone Number of Institution (number and street):

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

# ENROLLMENT FORM

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 Medicare Blue PPO outside of these periods.

- I am new to Medicare.
- I recently moved outside of my current Medicare health plan's or Medicare prescription drug plan's service area.
- 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.

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:   /   /

If none of these statements applies to you, or if you are not sure, please contact us at our Customer Service department at 1-866-303-2583, 8 a.m. – 8 p.m., local time, Monday through Friday, to see if you are eligible to enroll. For the hearing or speech impaired, please call 1-800-722-0353.

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 Medicare Blue PPO could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Medicare Blue 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.

# ENROLLMENT FORM

## Please read and sign below:

**By completing this enrollment application, I agree to the following:** Medicare Blue 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 Medicare Blue 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.

Medicare Blue PPO serves a specific service area. If I move out of the Medicare Blue 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 Medicare Blue 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 Medicare Blue PPO when I receive it to know which rules I must follow in order to receive coverage with Medicare Blue 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 Medicare Blue PPO coverage begins, I must get all of my health care from Medicare Blue PPO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Medicare Blue PPO and other services contained in my Medicare Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE BLUE 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 Medicare Blue 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 Medicare Blue PPO or by Medicare.

Your Signature:

X

Today's Date:

/ /

**If you are the authorized representative, you must attach a copy of proof of Legal Guardian, DPAHC or proof of authorization by state law. Please provide the following information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

### Medicare Blue PPO Office Use Only:

Name of Staff Member (if assisted in enrollment): \_\_\_\_\_

Plan ID#: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ICE/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_

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

<sup>SM</sup>Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

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