

MedicareBluePPOSM

2010 Individual Enrollment Form

Follow these easy steps:

1. Review the Summary of Benefits included in your 2010 Medicare Blue PPO enrollment kit.

2. Enroll:

- Complete and return this form in the enclosed postage-paid envelope. Keep the blue copy for your files. If you don't have a postage-paid envelope (see last page), please mail your completed enrollment form to:

Medicare Blue PPO, P.O. Box 3327, Tulsa, OK 74101-9917, or

- Call a Product Specialist to enroll over the phone at the number below, or

- Contact your authorized independent agent

For assistance with eligibility, enrollment, or for information in another format, call:

1-866-303-2583

TTY/TDD 1-800-722-0353

Hours of Operation: 8 a.m. - 5 p.m., Central time, Monday through Friday

For the hearing or speech impaired, please call 1-800-722-0353

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

Spanish

Please contact Medicare Blue PPO at 1-866-303-2583 if you need information in another format or language than what is listed to the left. TTY users should call

Braille

1-800-722-0353. Our office hours are 8 a.m. - 5 p.m., Central time, Monday through Friday

STOP

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. You could lose your

employer or union health coverage if you join Medicare Blue PPO. 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.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a 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/prescription help](http://www.socialsecurity.gov/prescription%20help).

Subscriber acknowledges this agreement is a contract solely with Blue Cross and Blue Shield of Oklahoma (BCBSOK), an independent licensee of the Blue Cross Blue Shield Association, and that BCBSOK is not contracting as the agent of the Association. Subscriber acknowledges that it has not entered into this agreement based on representations by any other party than BCBSOK and that no person or entity, other than BCBSOK shall be held accountable or liable to Subscriber for any of BCBSOK's obligations under this agreement.

To enroll in Medicare Blue PPOSM, please provide the following information:

Please check which plan you want to enroll in:			
<input type="checkbox"/> Medicare Blue PPO with prescription drugs	\$88.10 a month	<input type="checkbox"/> Medicare Blue PPO Basic without prescription drugs	\$24.60 a month
Last Name:		LC:	
First Name:		Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	
Permanent Residence Street Address (P.O. Box is not allowed:)			
Street Address:			
City:		State:	ZIP Code:
Mailing Address: (only if different from your Permanent Residence Address)			
Street Address:			
City:		State:	ZIP Code:
Optional Information:			
E-mail Address:			
Emergency contact:			
Phone Number:		Relationship to You:	
Please Provide Your Medicare Insurance Information.			
<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> • Please fill in these blanks so they match your red, white and blue Medicare card. <p>- OR -</p> <ul style="list-style-type: none"> • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>		 <p>Name: _____</p> <p>Medicare Claim Number _____ Sex <input type="checkbox"/></p> <p>_____ is Entitled To _____ Effective Date _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>	

Paying Your Premium	
<p>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.</p>	
Select a payment option: <input type="checkbox"/> Receive a bill <input type="checkbox"/> Monthly Electronic Funds Transfer (EFT) <input type="checkbox"/> Deduct from SSA check	
Account holder name:	
Bank routing number:	Bank account number:
Account type: <input type="checkbox"/> Checking (Enclose a voided check.) <input type="checkbox"/> Saving	

Please Provide Information to Determine Enrollment Periods.

Review the following statements carefully and check the box of the statement that, to the best of your knowledge, applies to you. If additional information is necessary, we will contact you.

(i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage.) Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

- I am new to Medicare.
- I no longer qualify for extra help paying for my Medicare prescription drug coverage.
- I have moved and this plan is a new option for me.
- 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 or recently moved out of a long-term care facility (for example, a nursing home).
- 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 leaving employer or union 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.
- None of these statements apply to me. Please contact Medicare Blue PPO at 1-866-303-2583, 8 a.m. – 5 p.m., Central time, Monday through Friday, to see if you are eligible to enroll. For the hearing or speech impaired, please call 1-800-722-0353.

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 us to accommodate your requested date. Your enrollment letter will include your actual date.)

Please Answer the Following Questions:

- 1.** Do you have End Stage Renal Disease (ESRD)? Yes No
If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, please attach a note or records from your doctor showing you don't 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: | | Phone Number: | |
| Street Address: | City: | State: | ZIP Code: |
- 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 read carefully before signing below

By completing this enrollment application, I agree to the following:

Medicare Blue PPO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can only be in 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. 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: November 15 - December 31 of every year), or under certain special circumstances.

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, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Medicare Blue PPO provides reimbursement for all covered benefits, even if received out-of-network. 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.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Medicare Blue PPO, he/she may be compensated based on my enrollment in Medicare Blue PPO.

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 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 Medicare Blue PPO or by Medicare.

Enrollee Signature:

Today's Date:

X _____

□□/□□/□□□□

If you are the authorized representative (i.e. power of attorney), you must sign below and provide the following information:

Name:

Phone #: ()

Address:

City:

State:

ZIP:

Relationship to Enrollee:

Authorized Representative Signature:

X _____

Please indicate who should receive all required notifications and plan materials:

Enrollee Authorized Representative listed above Both

SMService Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

[®]Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Blue Cross and Blue Shield of Oklahoma 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 H3709 with the Centers for Medicare and Medicaid Services.

White copy - Blue Medicare Rx (PDP)

Blue Copy - Enrollee

Medicare Blue PPO Plan Use Only:

Name of Staff Member (if assisted in enrollment):

Plan ID #:

Effective Date of Coverage: _____ ICE/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____
Date: / /

Plan Representative Signature: X _____

Certified Agent/Producer Information (If Applicable):

As the producer signing this application, I attest that I have completed the CMS required 2010 **annual** Medicare prescription drug plan training and certification provided by Blue Cross and Blue Shield of Oklahoma. I further attest that all information provided in this section is true. I understand that providing false information can lead to disciplinary action up to and including loss of commission payments and termination of the Medicare Blue PPO amendment.

This section **MUST** be completed by the certified PRODUCER who assisted in this enrollment. The Certified Producer/Agency "Assigned Number" indicated below will be used to validate certification and provide compensation to the Certified Producer OR Agency (if applicable).

Please print:

Name: _____ BCBSOK Assigned Number: _____

Agency Name (if applicable): _____ Agency ID: _____

Producer Signature: X _____ Date: / /

Producer Phone Number: () _____

Scope of Appointment:

	Yes	No
Did you meet with the enrollee in person?	<input type="checkbox"/>	<input type="checkbox"/>

If yes:

Did you retain a copy of the signed Scope of Appointment Form?	<input type="checkbox"/>	<input type="checkbox"/>
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If no:

Did you use the Audio Audit recording service to set up the appointment?	<input type="checkbox"/>	<input type="checkbox"/>
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List the date and time of the appointment. Date: / / Time: _____