MEDICARE ADVANTAGE

2016

Employer Group

Abbreviated Enrollment Application for Current Members

Senior Blue HMO 699

Forever Blue Medicare PPO 799 Low Option

Forever Blue Medicare PPO 751

Forever Blue Medicare PPO 799

Senior Blue HMO 651

Forever Blue Medicare PPO Value

Bar Association of Erie County Retirees

If you are changing plans within Senior Blue HMO or Forever Blue Medicare PPO, you should use this form. This form may not be used to enroll in Senior Blue HMO or Forever Blue Medicare PPO for the first time.

If you have any questions, we're here to help!

bcbswny.com/medicare

1-800-329-2792
(TTY 711)

October 1-February 14	8 a.m. to 8 p.m., 7 days a week
February 15-September 30	8 a.m. to 8 p.m., Monday-Friday

Mailing Address:
P.O. Box 5204
Binghamton, NY 13902

Physical Address:
257 West Genesee St.
Buffalo, NY 14202

A division of HealthNow New York Inc., an independent licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Western New York is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal.

BlueCross BlueShield
of Western New York

PART 1 Please tell us about yourself

Name of plan you are enrolling in:

Last Name | First Name | Initial

Member Number | Home Phone Number

Permanent Street Address (PO Box is not allowed)

Street/Apartment # | City

State | County | ZIP Code

Mailing Address (If different from permanent address):

Street/Apartment # | City

State | ZIP Code

PART 2 I am currently a member of (please check one):

- ☐ Senior Blue HMO 699
- ☐ Forever Blue Medicare PPO 799 Low Option
- ☐ Forever Blue Medicare PPO 751
- ☐ Forever Blue Medicare PPO 799
- ☐ Senior Blue HMO 651
- ☐ Forever Blue Medicare PPO Value

PART 3 I would like to change to (please check one):

- ☐ Senior Blue HMO 699
- ☐ Forever Blue Medicare PPO 799 Low Option
- ☐ Forever Blue Medicare PPO 751
- ☐ Forever Blue Medicare PPO 799
- ☐ Senior Blue HMO 651
- ☐ Forever Blue Medicare PPO Value

Effective Date:

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

PART 4 Name of chosen Primary Care Physician (PCP), clinic, or health center.

Name

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

☐ **Language (call for availability)** ☐ **Alternate Formats (call for availability)**

Please contact BlueCross BlueShield of Western New York at 1-800-329-2792 if you need information in another format or language than what is listed above. TTY users should call 711. Our office hours are:

October 1-February 14	8 a.m. to 8 p.m., 7 days a week
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Your Plan Premium

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 Railroad Retirement Board. Do NOT pay BlueCross BlueShield of Western New York the Part D-IRMAA.

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 qualify 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 for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please Read and Sign the Next Page:

BlueCross BlueShield of Western New York is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BlueCross BlueShield of Western New York, he/she may be paid based on my enrollment in BlueCross BlueShield of Western New York.

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 BlueCross BlueShield of Western New York 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date BlueCross BlueShield of Western New York coverage begins, I must get all of my health care from BlueCross BlueShield of Western New York, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BlueCross BlueShield of Western New York and other services contained in my BlueCross BlueShield of Western New York Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUECROSS BLUESHIELD OF WESTERN NEW YORK WILL PAY FOR THE SERVICES.

PART 5 Enrollee Authorization

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 from Medicare.

Signature **X**_____ Date _____ / _____ /_____

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

Last Name _____ First Name _____ Initial _____

Street/Apartment # _____

City _____ State _____ County _____ ZIP Code _____

Telephone (_____) _____ Relationship to Enrollee _____

Please include a copy of your Power of Attorney paperwork.

Office Use Only

Senior Blue HMO 699	Forever Blue Medicare PPO 799	Forever Blue Medicare PPO 799 Low Option
Group Number 00402745	Group Number 00403921	Group Number 00418167
Class ID 0120	Class ID 0120	Class ID 0180
Sub Group	Sub Group	Sub Group
Senior Blue HMO 651	Forever Blue Medicare PPO 751	Forever Blue Medicare PPO Value
Group Number 00402745	Group Number 00401524	Group Number 00401524
Class ID 0011	Class ID 0002	Class ID 0026
Sub Group	Sub Group	Sub Group

Effective Date: _____ Election Type: _____ Employer Group: _____