MEDICARE ADVANTAGE

2016

Employer Group

Enrollment Application

Senior Blue HMO 699

Forever Blue Medicare PPO 799

Forever Blue Medicare PPO 799 Low Option

Bar Association of Erie County Retirees

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

bcbswny.com/medicare

1-855-215-9237
(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.

5490_8_15

Please contact BlueCross BlueShield of Western New York if you need information in another language or format (Braille).

To Enroll in BlueCross BlueShield of Western New York, please provide the following information:

Employer or Union Name Bar Association of Erie County Retirees

Please check which plan you want to enroll in:

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

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

Effective Date: ____________

Last Name **First Name** **Middle Initial** ☐Mr. ☐Mrs. ☐Ms.

Birth Date __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

Sex ☐ M ☐ F

Home 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**

Email Address

Please Provide Your Medicare Insurance Information

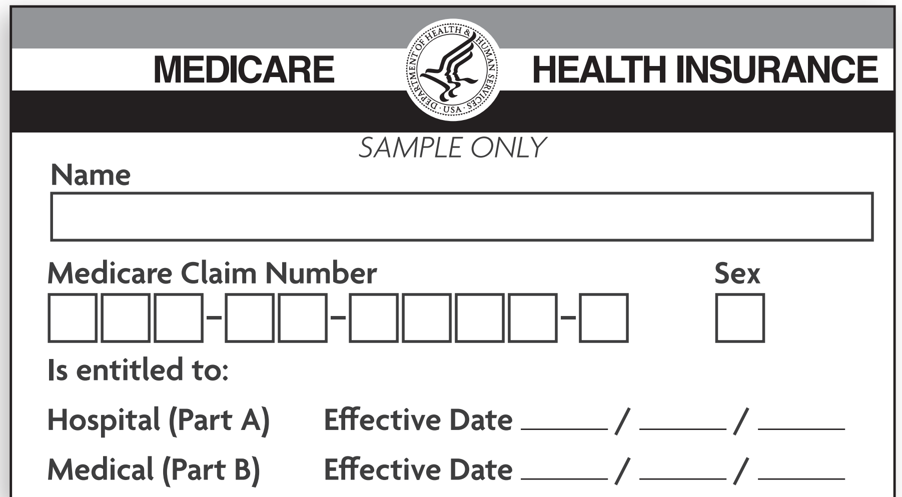
Please take out your Medicare card to complete this section.

- 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.



Please read and answer these important questions

1 Are you the retiree? ☐ Yes ☐ No

If "yes", retirement date (month/date/year): __________

If "no", name of retiree: __________

2 Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If "yes", name of spouse: __________

An application must be completed for each member

Name of dependents:

__________ __________

__________ __________

3 Do you or your spouse work? ☐ Yes ☐ No

Please complete the CMS Working Aged Survey on page 5.

4 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 any more, ***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.

5 Some individuals may have other drug coverage, including other private insurance, worker's compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Senior Blue HMO or Forever Blue Medicare 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

6 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)

Please choose the name of a Primary Care Physician (PCP)

NOTE: Required for Senior Blue HMO enrollment; optional for Forever Blue Medicare PPO enrollment

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 1-855-215-9237 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
February 15-September 30	8 a.m. to 8 p.m., Monday-Friday

CMS Working Aged Survey

Are you working or self-employed?

☐ No ☐ Yes

1. Does your employer have 20 or more employees? ☐ Yes ☐ No
2. Do you have health coverage through your employer? ☐ Yes ☐ No
3. Does the employer group health plan cover prescription drugs? ☐ Yes ☐ No
4. Have you refused health coverage through your employer? ☐ Yes ☐ No
5. Tell us about your employer:

   Company

   Address

   Phone

6. Do you plan to leave your employment or retire in the next:

   ☐ 3 months ☐ 6 months ☐ 1 year ☐ No plans

END OF SURVEY

Are you married?

☐ No ☐ Yes

END OF SURVEY

1. Spouse's Name
2. Is your spouse working or self-employed?

   ☐ Yes ☐ No *END OF SURVEY*

3. Does your spouse's employer have 20 or more employees? ☐ Yes ☐ No
4. Does your spouse have health coverage through his/her employer:

   ☐ Yes ☐ No *END OF SURVEY*

5. Tell us about your spouse's employer:

   Company

   Address

   Phone

6. Does your spouse's health plan include coverage for you? ☐ Yes ☐ No
7. Does the employer group health plan cover prescription drugs? ☐ Yes ☐ No
8. Does your spouse plan to leave his/her employment or retire in the next:

   ☐ 3 months ☐ 6 months ☐ 1 year ☐ No plans

Please Read and Sign the next page

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

BlueCross BlueShield of Western New York 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.

Senior Blue HMO and Forever Blue Medicare PPO serves a specific service area. If I move out of the area that Senior Blue HMO or Forever Blue Medicare PPO 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 Senior Blue HMO or Forever 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 Senior Blue HMO or Forever Blue Medicare PPO 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 Senior Blue HMO 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. I understand that beginning on the date Forever Blue Medicare PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Forever Blue Medicare PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by BlueCross BlueShield of Western New York and other services contained in my Senior Blue HMO or Forever Blue Medicare PPO 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.

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 Senior Blue HMO or Forever Blue Medicare PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that BlueCross BlueShield of Western New York 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 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.

Enrollee Authorization

Signature **Today's Date**

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

Name

Address

Phone Number

( )

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	
Group Number		Group Number		Group Number	
Class ID		Class ID		Class ID	
Sub Group		Sub Group		Sub Group	

Effective Date: ______________________ Election Type: ______________________ Employer Group: ______________________