MEDICARE ADVANTAGE

2017

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!

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 80
Buffalo, NY 14240

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

2677_9_16

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
- ☐ Forever Blue Medicare PPO 799 Low Option
- ☐ Senior Blue HMO 651
- ☐ Forever Blue Medicare PPO 751
- ☐ 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
- ☐ Forever Blue Medicare PPO 799 Low Option
- ☐ Senior Blue HMO 651
- ☐ Forever Blue Medicare PPO 751
- ☐ 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 1-855-215-9237 if you need information in another format or language than what is listed above. TTY users should call 711. Our office hours are:

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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	0001	Sub Group	0001	Sub Group	0001
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	0001	Sub Group	0001	Sub Group	0001

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

Notice of nondiscrimination

BlueCross BlueShield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueCross BlueShield of Western New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueCross BlueShield of Western New York:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact Carleen Dunne, Director, Corporate Compliance & Privacy Officer.

If you believe that BlueCross BlueShield of Western New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Carleen Dunne, Director, Corporate Compliance & Privacy Officer, 257 W Genesee St., Buffalo, NY 14202, 716-887-8624, 716-887-6056, **dunne.carleen@bcbswny.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michele Salerno, Regulatory Compliance Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-215-9237 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-215-9237 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-215-9237（TTY：711）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-215-9237 (телетайп: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-215-9237 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-215-9237 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-215-9237 (TTY: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-215-9237 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-855-215-9237 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-215-9237 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-215-9237 (رقم هاتف الصم والبكم: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-215-9237 (ATS : 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-215-9237 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-215-9237 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-215-9237 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-215-9237 (TTY: 711).