MEDICARE ADVANTAGE

2017

Employer Group

Enrollment Application

Forever Blue Medicare PPO 799 OOA

Bar Association of Erie County Retirees 799 OOA

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

5490_8_16

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 799 OOA

Please check which plan you want to enroll in:

- ☐ Forever Blue Medicare PPO 799 OOA
- ☐
- ☐
- ☐
- ☐
- ☐

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

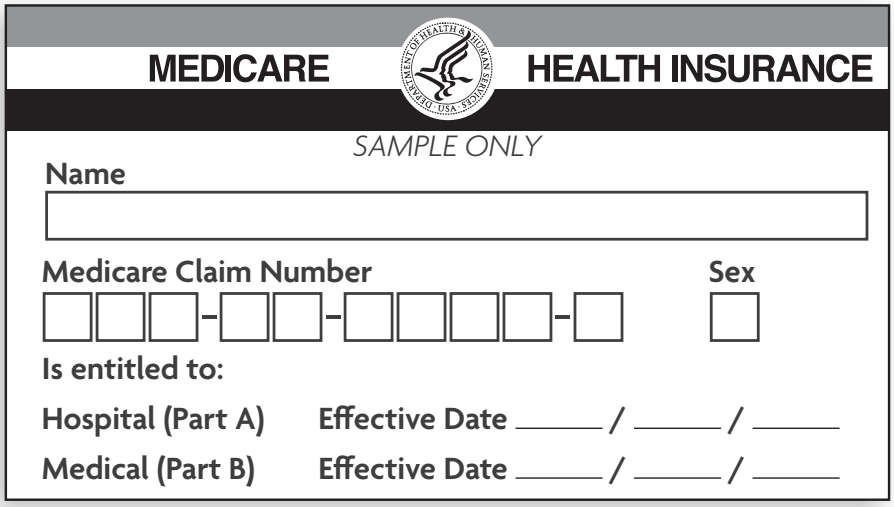
Please take out your Medicare card to complete this section.

- 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.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name

Medicare Claim Number ☐☐☐-☐☐-☐☐☐☐-☐ Sex ☐

Is entitled to:

Hospital (Part A) Effective Date ____ / ____ / ____

Medical (Part B) Effective Date ____ / ____ / ____

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

END OF SURVEY

☐ Yes

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 below

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

Forever Blue Medicare PPO 799 OOA

Group Number	00403921	Group Number	Group Number
Class ID	OOA1	Class ID	Class ID
Sub Group	0001	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: _____

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. BlueShield of Northeastern 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).