

MEDICARE ADVANTAGE 2018 GROUP ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another format (Braille), please call 1-855-215-9237 (TTY 711).



BlueCross BlueShield
of Western New York

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

PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Employer or Union Name **Bar Association of Erie County Retirees - 699 & 799 In-Area**

- | | |
|---|--|
| <input type="checkbox"/> Senior Blue HMO 699 | <input type="checkbox"/> Forever Blue Medicare PPO 799 |
| <input type="checkbox"/> Forever Blue Medicare PPO 799 Low Option | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Effective Date _____

PART 2 PLEASE TELL US ABOUT YOURSELF

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (MM/DD/YYYY) _____ Gender M F Mr. Mrs. Ms.

Email Address _____

PERMANENT RESIDENCE ADDRESS (P.O. BOX IS NOT ALLOWED):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number () _____ Area code
Alternative Phone Number () _____ Area code

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 3 MEDICAL ELIGIBILITY INFORMATION

Please take out your red, white, and blue Medicare card to complete this section.

or

Attach a copy of your Medicare Card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number

Entitled to:

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

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

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

PART 4 PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY

Doctor's Last Name _____ First Name _____

Current Patient? Yes No

NOTE: Required for all HMO plan enrollment; optional for all PPO plan enrollment

PART 5 PLEASE READ AND ANSWER THESE QUESTIONS

1. Are you the retiree? Yes No

If YES, retirement date (MM/DD/YYYY) _____

If NO, name of retiree _____

2. Are you the spouse of the retiree? Yes No

3. Are you covering a spouse or dependents under this employer or union plan? Yes No

If YES, name of spouse _____

Name of dependents _____

4. Do you have End Stage Renal Disease (ESRD)? Yes No

ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **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, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or EPIC. Will you have other prescription drug coverage in addition to the plan in which you are reenrolling? 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 list the institution's name, address, phone number, and date of admission.

Name _____ Street _____ Suite# _____

City _____ State _____ Zip Code _____

Phone () _____ County _____ Date of Admission _____
area code (MM/DD/YYYY)

7. Are you enrolled in your state Medicaid program? Yes No

If YES, please provide your Medicaid number _____

8. Do you, on you own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or VA benefits? Yes No

If YES, what kind of insurance do you have? _____

What is the name of your insurance? _____

9. Do you or does your spouse work? Yes No

10. Please check one of the boxes below if you would prefer we send you information in another format.

Large print Braille Other _____

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 PPO serve a specific service area. If I move out of the area that Senior Blue HMO or Forever Blue 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 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 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 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 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 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 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 that 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.

PART 7 ENROLLEE AUTHORIZATION

Enrollee Authorization

Signature _____

Today's Date _____

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

Last Name _____ First Name _____ Middle Initial _____

Street/Apartment# _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number () _____ Relationship to Enrollee _____
area code

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
Subgroup 0001	Subgroup 0001	Subgroup 0001
blank	blank	blank
Group Number	Group Number	Group Number
Class ID	Class ID	Class ID
Subgroup	Subgroup	Subgroup
Effective Date _____	Election Type _____	Employer Group _____

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Our office hours are:

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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.