MEDICARE ADVANTAGE 2019 GROUP ENROLLMENT APPLICATION

BlueCross BlueShield
of Western New York

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).

8 a.m. to 5 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**

☐ **BlueSaver HMO**	**Group Bill**	☐ **Senior Blue 651**	**Group Bill**
☐ **Forever Blue PPO 751**	**Group Bill**	☐ **Forever Blue PPO Value**	**Group Bill**
☐ **blank**		☐ **blank**	

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 ( ) _____ Alternative Phone Number ( ) _____
area code 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

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 <u>prescription drug coverage</u> in addition to the plan in which you are re-enrolling?** ☐ 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 _____

PART 6 **PLEASE READ AND SIGN ON PAGE 4**

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. 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 if an enrollment period is available (example: annual enrollment period from October 15 – December 7), 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

BlueSaver HMO	Group Bill	Senior Blue 651	Group Bill	Forever Blue PPO 751	Group Bill
Group Number 00402745		Group Number 00402745		Group Number 00401524	
Class ID 0100		Class ID 0011		Class ID 0002	
Subgroup 0001		Subgroup 0001		Subgroup 0001	
Forever Blue PPO Value	**Group Bill**				
Group Number 00401524		Group Number		Group Number	
Class ID 0026		Class ID		Class ID	
Subgroup 0001		Subgroup		Subgroup	

Effective Date _____ Election Type _____ Employer Group _____

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