2021 Medicare Blue Choice® (HMO) and (HMO-POS) Individual Enrollment Request Form

Excellus BlueCross BlueShield is an HMO plan with a Medicare contract.
Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

Rochester B-3689Y21

Y0028_7437_C

OMB No. 0938-1378
Expires: 7/31/2023

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

WHO CAN USE THIS FORM?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

WHEN DO I USE THIS FORM?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

WHAT DO I NEED TO COMPLETE THIS FORM?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1 and Section 3. The items in Section 2 are optional - you can't be denied coverage because you don't fill them out.

REMINDERS:

- If you want to join a plan during fall open enrollment (October 15 - December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

WHAT HAPPENS NEXT?

Send your completed and signed form to:

Excellus BlueCross BlueShield

Attn: Medicare Enrollment Processing
PO Box 211316
Eagan, MN, 55121

Once they process your request to join, they'll contact you.

HOW DO I GET HELP WITH THIS FORM?

Call Excellus BlueCross BlueShield at 1-800-659-1986. TTY users can call 1-800-662-1220.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Excellus BlueCross BlueShield al 1-800-659-1986/TTY 1-800-662-1220 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

- ☐ Medicare Blue Choice® Advanced (HMO-POS) $39 per month
- ☐ Medicare Blue Choice® Value (HMO) $80 per month
- ☐ Medicare Blue Choice® Value Plus (HMO-POS) $158 per month
- ☐ Medicare Blue Choice® Optimum (HMO-POS) $256 per month

☐ Optional Complementary Dental $29 per month

- ☐ Medicare Blue Choice® Select (HMO) $0 per month
- ☐ Medicare Blue Choice® Platinum (HMO-POS) $117 per month

☐ Optional Full Comprehensive Dental $39 per month

FIRST NAME: **LAST NAME:** **MIDDLE INITIAL:**

BIRTH DATE (MM/DD/YYYY): **SEX:** ☐ MALE ☐ FEMALE **PHONE NUMBER:**

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY: **COUNTY:** **STATE:** **ZIP CODE:**

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):

STREET ADDRESS: **CITY** **STATE:** **ZIP CODE:**

Your Medicare Information:

MEDICARE NUMBER:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Excellus BlueCross BlueShield?
☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

IMPORTANT: Read and Sign on the Next Page:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Excellus BlueCross BlueShield.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Excellus BlueCross BlueShield will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Excellus BlueCross BlueShield coverage begins, I must get all of my medical and

IMPORTANT: Read and Sign Below:

prescription drug benefits from Excellus BlueCross BlueShield. Benefits and services provided by Excellus BlueCross BlueShield and contained in my Excellus BlueCross BlueShield "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Excellus BlueCross BlueShield will pay for benefits or services that are not covered.

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Signature: **Today's Date:**

If you're the authorized representative, sign above and fill out these fields:

NAME: **ADDRESS:**

PHONE NUMBER: **RELATIONSHIP TO ENROLLEE:**

Section 2 - All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Contact us if you would prefer us to send you information in a language other than English, or in an accessible format.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP):

E-mail Address:

Section 3 - Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Excellus BlueCross BlueShield the Part D-IRMAA.

If you will be receiving any form of premium assistance due to Low Income Subsidy or EPIC, you must continue to pay the amount on your monthly bill. Your bill will reflect the lower premium once the notification has been received and applied to your account.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ **Get a bill each month.**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a VOIDED check or provide the following:

ACCOUNT HOLDER NAME:

BANK ROUTING NUMBER:

BANK ACCOUNT NUMBER:

ACCOUNT TYPE:

☐ CHECKING

☐ SAVINGS

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from:

☐ Social Security

☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. **Any plan premiums due prior to the Social Security or RRB withhold start date will not be deducted from your check; therefore, you are still responsible for any outstanding premiums owed prior to the point withholding begins.** If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Send completed application to:
Excellus BlueCross BlueShield Attn: Medicare Enrollment Processing, PO Box 211316, Eagan, MN, 55121

Office Use Only:		Plan ID#:	
Effective Date of Coverage:			
ICEP / IEP:	OEPI:	AEP / MA OEP:	SEP (type):
Name of staff member/agent/broker (if assisted in enrollment):			Not Eligible:
Agent/Broker Signature:		**NPN: #**	**Date Received:**

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me.
  I moved on (insert date)_____.
- ☐ I recently was released from incarceration. I was released on (insert date)_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S.
  I returned to the U.S. on (insert date)_____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)_____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____.
- ☐ I recently left a PACE program on (insert date)_____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
  I lost my drug coverage on (insert date)_____.
- ☐ I am leaving employer or union coverage on (insert date)_____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)_____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Excellus BlueCross BlueShield at 1-800-659-1986 (TTY users should call 1-800-662-1220) to see if you are eligible to enroll. We are open Monday - Friday, 8:00 a.m. - 8:00 p.m. From October 1 - December 30, 8:00 a.m. - 8:00 p.m., 7 days a week.

Discrimination is Against the Law

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Our Health Plan:

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, contact our dedicated Medicare Customer Care representatives at 1-877-883-9577, (TTY: 1-800-662-1220). Monday - Friday, 8 a.m. - 8 p.m.
From October 1 - March 31, 8 a.m. - 8 p.m., 7 days a week.

If you believe that our Health Plan 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:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone Number: 1-800-614-6575 (TTY: 1-800-662-1220)
Fax Number: 315-671-6656

You can file a grievance in person, or by mail or fax. If you need help filing a grievance, our Health Plan's Civil Rights Coordinator 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

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

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-883-9577 (TTY: 1-800-662-1220).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-883-9577 (TTY: 1-800-662-1220).

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 1-877-883-9577 (TTY：1-800-662-1220）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-883-9577 (телетайп: 1-800-662-1220).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-883-9577 (TTY: 1-800-662-1220).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-883-9577 (TTY: 1-800-662-1220)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-883-9577 (TTY: 1-800-662-1220).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-877-883-9577 (TTY: ১-800-662-1220)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-883-9577 (TTY: 1-800-662-1220).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-883-9577 (رقم هاتف الصم والبكم: 1-800-662-1220).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-883-9577 (ATS : 1-800-662-1220).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-883-9577 (TTY: 1-800-662-1220).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-883-9577 (TTY: 1-800-662-1220).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-883-9577 (TTY: 1-800-662-1220).

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Sales Appointment Confirmation Form

Please initial the box below beside the plan you want the agent to discuss with you.

☐ Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only go to doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.*

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) -- A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost plans, some Medicare Private Fee-for-Service plans, and Medicare Medical Savings Account plans.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. The person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal Government. This individual may also be compensated based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

_____

Beneficiary or Authorized Representative Signature: **Signature Date:**

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	Plan(s) represented during this meeting:
Agent, if the form was signed by the beneficiary at the time of appointment, provide an explanation why SOA was not documented prior to meeting:	
Agent's Signature:	Date appointment was completed:

*For PPO Plans: Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Customer Care number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-659-1986 (TTY: 1-800-662-1220).

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Excellus BlueCross BlueShield • 165 Court Street, Rochester, NY 14647

ExcellusMedicare.com

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