# MEDICARE ADVANTAGE 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).

**Monday – Friday, 8 a.m. – 5 p.m.**

Mailing Address: P.O. Box 80 • Buffalo, NY 14240
Physical Address: 257 West Genesee St. • Buffalo, NY 14202

HIGHMARK® WESTERN NEW YORK

## PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Employer or Union Name **Bar Association of Erie County Medicare** Location: ______________________

**Member plan selection:**

☐ BlueSaver (HMO) ☐ Senior Blue Basic (HMO) ☐ Senior Blue Select (HMO) ☐ Senior Blue 651 (HMO)
☐ Freedom Nation (PPO) ☐ Forever Blue Value (PPO) ☐ Forever Blue 751 (PPO) ☐

**Effective Date** ______________________________ **Member bill level selection:** ☐ **Group bill** ☐ **Member bill**

## 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 (optional) ______________________________________________

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

Street/Apartment # ____________________________________________________________

City ______________________________ State ______ County ______________ ZIP Code ____________

Home Phone Number (      ) ______________________ Alternative Phone Number (      ) ______________________

**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. **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 ______________

5. **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 (MM/DD/YYYY) ______________

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number ______________________

7. **Do you, on your 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? ______________________

8. **Do you or does your spouse work?** ☐ Yes ☐ No

9. **Please check one of the boxes below if you want us to send you information in a language other than English.**

   ☐ Spanish ☐ Chinese ☐ Russian ☐ Other ______________________

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

    ☐ Large print ☐ Braille ☐ Audio CD ☐ Other ______________________

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

**By completing this enrollment application, I agree to the following:**

Highmark Blue Cross Blue Shield 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 once I receive 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 Highmark Blue Cross Blue Shield 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 Highmark Blue Cross Blue Shield 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 HIGHMARK BLUE CROSS BLUE SHIELD 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 Highmark Blue Cross Blue Shield of Western New York, the employee 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 Highmark Blue Cross Blue Shield 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 Highmark Blue Cross Blue Shield 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.

## 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 ______________

**Please include a copy of your Power of Attorney paperwork.**

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ **I choose not to answer.**
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ **I choose not to answer**
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan

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## NOTICE OF NONDISCRIMINATION

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

The 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)
- 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 member ID card or contact the Civil Rights Coordinator.

If you believe that the 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: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

**For assistance in English, call the customer service number listed on your member ID card.**

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

**বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।**

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d’identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee