BlueCross BlueShield of Montana

# Blue Cross Medicare Advantage℠ Individual Enrollment Form

Please contact Blue Cross Medicare Advantage if you need information in another language or format (Braille).

## To enroll in Blue Cross Medicare Advantage, please provide the following information:

Please check the plan you want to enroll in: **(Check ONLY one)**

**PPO Options:**

☐ **Blue Cross Medicare Advantage Choice Plus (PPO)℠**
$35.00 per month

☐ **Blue Cross Medicare Advantage Choice Premier (PPO)℠**
$69.00 per month

| 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: ( ) | Alternate Phone Number: ( ) |
|---|---|---|---|
| | | | |

**Permanent Residence Street Address (P.O. Box is not allowed):**

| City: | County: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

**Mailing Address (only if different from your Permanent Residence Address):**

Street Address: City: State: ZIP Code:

Emergency Contact:

Phone Number: Relationship to You:

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

Name: SAMPLE ONLY

Medicare Claim Number Sex ____

— — — - — — - — — — —

is Entitled To Effective Date

**HOSPITAL (Part A)** _____

**MEDICAL (Part B)** _____

Applicant LAST name: FIRST name:

## 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 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums. | |
| ☐ I get Extra Help paying for Medicare prescription drug coverage. | |
| ☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date). | / / |
| ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or a 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 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). | / / |

**If none of these statements applies to you or you're not sure, please contact Blue Cross Medicare Advantage at 1-877-774-8592 (TTY/TDD users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. From February 15 - September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.**

| Applicant LAST name: | FIRST name: |
|---|---|

## Paying Your Plan Premium

**You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe), by mail or by Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Blue Cross and Blue Shield of Montana (BCBSMT) the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

## Please select a premium payment option:

☐ Get a bill

☐ 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 ☐ Saving

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up 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.)

Applicant LAST name: FIRST name:

**Please read and answer these important questions:**

**1.** 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.

**2.** Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Blue Cross Medicare Advantage? ☐ 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: _____

**3.** 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):

_____

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

If yes, please provide your Medicaid number: _____

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

**6.** Do you have a Medicare Advantage policy in force that you will be replacing?

☐ Yes ☐ No

If yes, with what company? _____

_____

**Please choose the name of a Primary Care Physician (PCP), clinic or health center:**

| PCP First Name: | PCP Last Name: | PCP ID#: | Current Patient: ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

**Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:**

☐ Spanish

☐ Braille/Large Print

Please contact Blue Cross Medicare Advantage at 1-877-774-8592 (TTY/TDD users should call 711.) if you need information in another format or language than what is listed above. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

| Applicant LAST name: | FIRST name: |
|---|---|
| | |

## Please Read This Important Information


**If you currently have health coverage from an employer or union, joining Blue Cross Medicare Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross Medicare Advantage.** Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## Please Read and Sign Below

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

Blue Cross Medicare Advantage 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. 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.

Blue Cross Medicare Advantage serves a specific service area. If I move out of the area that Blue Cross Medicare Advantage 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 Blue Cross Medicare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross Medicare Advantage 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 Blue Cross Medicare Advantage 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, Blue Cross Medicare Advantage provides refunds for all covered benefits, even if I get services out of network. Services authorized by Blue Cross Medicare Advantage and other services contained in my Blue Cross Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE CROSS MEDICARE ADVANTAGE 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 Blue Cross Medicare Advantage, he/she may be paid based on my enrollment in Blue Cross Medicare Advantage.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and BCBSMT, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSMT to use the Blue Cross and/or Blue Shield Service Marks in the State of Montana, and that BCBSMT is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSMT and that no person, entity, or organization other than BCBSMT shall be held accountable or liable to Subscriber for any of BCBSMT's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSMT other than those obligations created under other provisions of this agreement.

| Applicant LAST name: | FIRST name: |
|---|---|

## Please Read and Sign Below (continued)

**Release of Information:**

By joining this Medicare health plan, I acknowledge that Blue Cross Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross Medicare Advantage 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.

| **Signature:** | **Today's Date:** |
|---|---|
| If you are the authorized representative, you must sign above and provide the following information:<br>Name: | |
| Address: | |
| Phone Number: (  ) | Relationship to Enrollee: |

| **Office Use Only:** | | | |
|---|---|---|---|
| Plan ID #: | | Effective Date of Coverage: ☐☐/☐☐/☐☐ | |
| ☐ ICEP/IEP | ☐ AEP | ☐ SEP (type): | ☐ Not Eligible |

| Applicant LAST name: | FIRST name: |
|---|---|

| Agent Information | |
|---|---|
| To receive your compensation, you must complete the following information, and the enrollee must meet certain requirements (see information to right). If you do not complete this section of the form, you will not be paid for this enrollee.<br>As the producer, I attest that the following information is true. By signing this enrollment form, I understand that providing false information can lead to disciplinary action up to and including loss of compensation payments and/or termination of the Blue Cross Medicare Advantage amendment. | Requirements for compensation payments:<br>• Be licensed and, where applicable, appointed;<br>• Successfully completed the 2017 Blue Cross Medicare Advantage training and certification program prior to marketing, selling, signing any enrollment form or conducting service for Blue Cross Medicare Advantage; and<br>• Enrolled a member who has been approved by CMS and has not canceled their enrollment prior to becoming effective. |

| | Yes | No |
|---|---|---|
| I fulfilled the CMS annual training requirement by completing the 2017 AHIP and Blue Cross Medicare Advantage training and certification program requirements and did so before marketing, selling or conducting service with this enrollee. | ☐ | ☐ |
| **Method of Scope** | **Yes** | **No** |
| I conducted a personal face-to-face marketing appointment with this applicant. As a result, I have a signed Scope of Appointment and understand that I may be asked to provide this documentation as part of the Blue Cross Medicare Advantage Monitoring & Oversight Program. | ☐ | ☐ |
| ☐ Paper ☐ Electronic ☐ Telephone ☐ Seminar attendee — no SOA required<br>Please indicate the method by which this applicant's Scope of Appointment (SOA) was completed (Please check one). | **N/A** | |
| | **Yes** | **No** |
| I provided the enrollee with information about eligibility requirements, enrollment periods, lock-in provisions, benefits, premiums, use of network pharmacies, billing options and the availability of Extra Help prior to his or her completing this enrollment form. | ☐ | ☐ |

| Please enter the following information carefully and legibly. Accurate and timely compensation payments depend on this information. | | |
|---|---|---|
| Writing Agent ID# (This is your BCBSMT assigned ID#): ☐☐☐☐☐☐☐☐☐☐ (Not SSN or TID) | Phone Number: | |
| First Name: | Middle Initial: | Last Name: |
| Producer Signature: **X** | | Date: ☐☐/☐☐/☐☐ |

| Applicant LAST name: | FIRST name: |
|---|---|

**Electronic Application ID**

☐☐☐☐☐☐☐☐☐☐

Out-of-network/non-contracted providers are under no obligation to treat Plan/Part D Sponsor members, except in emergency situations. For a decision about whether we will cover an out-of network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is available for free in other languages. Please call our Customer Service number at 1-877-774-8592 (TTY/TDD users should call 711). We are open between 8:00 a.m. and 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

You must continue to pay your Medicare Part B premium.

PPO plans available in Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Cascade, Chouteau, Deer Lodge, Fergus, Flathead, Gallatin, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Lake, Lewis and Clark, Liberty, Lincoln, Madison, Meagher, Mineral, Missoula, Musselshell, Park, Pondera, Powell, Ravalli, Sanders, Silver Bow, Stillwater, Sweet Grass, Teton, Toole, Treasure, Wheatland, and Yellowstone counties.

PPO plans are provided by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.