



MASSACHUSETTS

Medicare | HMO Blue® PlusRx (HMO) 2010

To Complete Your Enrollment Form:

Be sure to complete all information, sign, and date your enrollment form. Please keep a copy of the enrollment form for your records. Return the completed form(s) in the enclosed envelope. If you lose the return envelope, mail your application to: Blue Cross Blue Shield of Massachusetts, Enrollment Department, P.O. Box 9202, North Quincy, MA 02171-9202. We will contact you in writing when we receive your enrollment form, and then again to notify you of your effective date. We will also telephone you to verify your enrollment and talk with you about your membership in the plan.

To Enroll in Medicare HMO Blue PlusRx, Please Provide the Following Information:

LAST Name:	FIRST Name:	Middle Initial:	Mr. Mrs. Ms.
Birth Date: (/ /) (MM/DD/YYYY)	Sex: M F	Home Phone Number: () -	Alternate Phone Number: () -
Permanent Residence Address:			
Number and Street: _____			
City: _____ State: _____ Zip: _____			
Mailing Address (only if different from your permanent residence address):			
Number and Street: _____			
City: _____ State: _____ Zip: _____			
Emergency Contact Name: _____			
Phone Number: _____ Relationship to You: _____			

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	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex ____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____

Paying Your Plan Premium

You can pay your monthly plan premium by mail, Electronic Funds Transfer, or you can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 monthly
- Electronic Funds Transfer (EFT) from your bank account each month. We will send you a brochure and form to enroll. (Please pay your premium by mail until you receive notification that your EFT payment option is activated.)
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please Read and Answer These Important Questions

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

If you answered "yes" to this question and you don't need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

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 Medicare HMO Blue PlusRx? Yes No

If "yes," please list your other coverage and your identification (ID)) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance? Yes No

What kind of coverage? _____ Name of your insurance company: _____

4. 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 & Address of Institution: _____

Phone Number of Institution: _____

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

If yes, please provide your Medicaid Number: _____

6. Do you or your spouse work? Yes No

7. Typically, you may enroll in a Medicare Advantage plan during the Annual Open Enrollment Period (AEP) between November 15th and December 31st each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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.

Please check any statement below that is true for you. We may contact you for additional information.

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 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 Medicare prescription drugs. I stopped receiving extra help on (insert date)._____

I recently "left" a PACE program 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 rehabilitation hospital). I moved /will move into/out of the facility on (insert date)_____.

I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least 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.

I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.

None of these statements applies to me.*

*Please contact Medicare HMO Blue PlusRx at the number listed below.

If you would prefer us to send you information in large print please contact Member Service at the number listed below.

Please choose the name of a Primary Care Provider (PCP): _____

Please list your PCP's ID Number: _____ Are you a current patient? Yes No



Questions? Contact Member Service at **1-800-200-4255 (TTY: 1-800-522-1254)**, 8:00 a.m. to 8:00 p.m., Monday – Friday, from Mar. 2 to Nov. 14; and 8:00 a.m. to 8:00 p.m., 7 days a week, from Nov. 15 to Mar. 2.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Medicare HMO Blue PlusRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Medicare HMO Blue PlusRx. 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 Last Page:

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

Medicare HMO Blue PlusRx 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 only be in 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: November 15 – December 31 of every year), or under certain special circumstances.

Medicare HMO Blue PlusRx serves a specific service area. If I move out of the area that Medicare HMO Blue PlusRx 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 Medicare HMO Blue PlusRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Medicare HMO Blue PlusRx 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 Medicare HMO Blue PlusRx coverage begins, I must get all of my health care from Medicare HMO Blue PlusRx, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Medicare HMO Blue PlusRx and other services contained in Medicare HMO Blue PlusRx Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE HMO BLUE PlusRx 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 Medicare HMO Blue PlusRx, he/she may be paid based on my enrollment in Medicare HMO Blue PlusRx.

Release of Information: By joining this Medicare health plan, I acknowledge that Medicare HMO Blue PlusRx will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Medicare HMO Blue PlusRx 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 by Medicare HMO Blue PlusRx or by Medicare.

Your Signature: _____

Today's Date: _____

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

Name: _____

Address: _____


Phone Number: (___) ___ - _____ Relationship to Enrollee: _____



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