MASSACHUSETTS

Medicare | HMO Blue®

2009

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.

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

Please check which plan you want to enroll in:
- ❑ Medicare HMO Blue PlusRx $119 per month
- ❑ Medicare HMO Blue PremierRx $173 per month

LAST Name: FIRST Name: Middle Initial: Mr. Mrs. Ms.

Birth Date: (/ /) (MM/DD/YYYY)

Sex: M F

Social Security Number: _ _ _ - _ _ - _ _ _ _ (optional)

Home 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 the Social Security Administration or 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 Check each month.

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 does not cover.

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

Please select a premium payment option:

- ❑ Receive 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 do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not 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 your Medicare HMO Blue plan? ❑ 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. 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: ____________

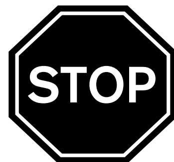
6. Do you or your spouse work? ❑ Yes ❑ No

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—unless you are newly eligible for Medicare or you are eligible for a Special Enrollment Period (SEP). Please check any statement below that is true for you. We will contact you for additional information.

- ❑ I recently moved outside of the service area for my current plan.
- ❑ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ❑ I was recently approved for extra help paying for Medicare prescription drug coverage.
- ❑ I recently "left" a PACE program.
- ❑ I moved "out" of a Long-Term Care Facility (for example, a nursing home or a rehabilitation hospital).
- ❑ I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare's).
- ❑ I am losing coverage I had from an employer.
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ I am no longer eligible for extra help paying for Medicare prescription drugs.

Please choose the name of a Primary Care Physician (PCP): ____________________

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



Please Read This Important Information

If you currently have health coverage from an employer or union, joining a Medicare HMO Blue plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining a Medicare HMO Blue plan may change how your current coverage works. 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 is no 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:

My Medicare HMO Blue plan is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my 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.

My Medicare HMO Blue plan serves a specific service area. If I move out of the area that my Medicare HMO Blue plan 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 a Medicare HMO Blue plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from the Medicare HMO Blue plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my Medicare HMO Blue plan coverage begins, I must get all of my health care from my Medicare HMO Blue plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by the Medicare HMO Blue plan and other services contained in my Medicare HMO Blue plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY MEDICARE HMO BLUE PLAN WILL PAY FOR THE SERVICES**.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that my Medicare HMO Blue plan 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 behalf of the individual under the laws of the state where the individual resides) 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 the Medicare HMO Blue plan 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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