MASSACHUSETTS

Blue Medicare | PFFS℠

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 Blue Medicare PFFS PlusRx, Please Provide the Following Information:

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.

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): __________

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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 Blue Medicare PFFS 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: ______________

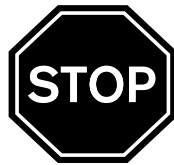
5. Are you enrolled in your state Medicaid program? ❑ Yes ❑ No

   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 Read This Important Information

Blue Medicare PFFS PlusRx, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at **www.bluecrossma.com/provider**.

Once Blue Medicare PFFS PlusRx has received your enrollment form, you will receive a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in Blue Medicare PFFS PlusRx. If Blue Medicare PFFS PlusRx is not able to reach you by telephone, then you will receive a letter by mail that contains similar information.

If you currently have health coverage from an employer or union, joining a Blue Medicare PFFS PlusRx plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining a Blue Medicare PFFS PlusRx 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:

Blue Medicare PFFS PlusRx is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health or Medicare 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

As a Medicare Private Fee-For-Service plan, Blue Medicare PFFS PlusRx works differently than a Medicare supplement plan. Blue Medicare PFFS PlusRx pays instead of Medicare, and I will be responsible for the amounts that Blue Medicare PFFS PlusRx does not cover, such as copayments and co-insurances. Original Medicare will not pay for my health care while I am enrolled in Blue Medicare PFFS PlusRx.

Before seeing a provider, I should verify that the provider will accept Blue Medicare PFFS PlusRx. I understand that my health care providers have the right to choose whether to accept a Private Fee-For-Service plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept Blue Medicare PFFS PlusRx, I will need to find another provider that will.

My Blue Medicare PFFS plan serves a specific service area. If I move out of the area that my Blue Medicare PFFS 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 Blue Medicare PFFS 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 Blue Medicare PFFS plan when I receive it to know which rules I must follow in order to receive coverage with this Private Fee-for-Service 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.

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 Blue Medicare PFFS 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 Blue Medicare PFFS 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: ____________________