2012 Medicare Blue Choice® (HMO-POS) and Medicare Blue® PPO Employer/Union Group Health Plan Enrollment Request Form

Excellus

Attn: Medicare Division
Excellus BlueCross BlueShield
P.O. Box 546
Buffalo, NY 14201-0546

B-3687 - Rochester Group

Please contact Excellus BlueCross BlueShield if you need information in another language or format (Braille).

To Enroll in Excellus BlueCross BlueShield, Please Provide the Following Information:

EMPLOYER OR UNION NAME

GROUP #

EFFECTIVE DATE (_ _ / _ _ / _ _ _ _)
M M D D Y Y Y Y

Please check which plan you want to enroll in:

☐ Medicare Blue Choice® (HMO-POS) ☐ Medicare Blue® PPO

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 ( )

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

COUNTY | CITY | STATE | ZIP CODE

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT RESIDENCE ADDRESS)

STREET ADDRESS | CITY | STATE | ZIP CODE

E-MAIL 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.

NAME SAMPLE ONLY

MEDICARE CLAIM NUMBER ☐☐☐-☐☐-☐☐☐☐-☐ SEX ☐

IS ENTITLED TO:

HOSPITAL (Part A) Effective Date M M / D D / Y Y Y Y

MEDICAL (Part B) Effective Date M M / D D / Y Y Y Y

Please read and answer these important questions:

1 Are you the retiree? ☐ YES ☐ NO

If yes, retirement date (month/date/year):

If no, name of retiree:

2 Do you or your spouse work? ☐ YES ☐ NO

If yes, please provide name of employer:

3 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.

4 Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. ☐ YES ☐ NO

Will you have other prescription drug coverage in addition to Excellus BlueCross BlueShield?

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

Name of other coverage:

ID# For this coverage:

5 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):

Please Choose a Primary Care Physician (PCP), clinic or health center:

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:

☐ Language (call for availability) ☐ Large Print

Please contact Excellus BlueCross BlueShield at 1-800-659-1986 if you need information in another format or language than what is listed. Our office hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. From October 15 – February 14, representatives are available seven days a week, 8:00 a.m. – 8:00 p.m. TTY users should call 1-800-421-1220.

Please Read and Sign Below

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

Excellus BlueCross BlueShield 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. 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.

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

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 Excellus BlueCross BlueShield 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:

NAME

RELATIONSHIP TO ENROLLEE

ADDRESS

PHONE NUMBER ( ) -

Send completed application to: Excellus BCBS, PO Box 546, Buffalo, NY 14201-0546

Office Use Only: **Plan ID#:** _____

Effective Date of Coverage: _____ ICEP / IEP: _____ AEP / MADP: _____ SEP (type): _____

Name of staff member/agent/broker (if assisted in enrollment): _____ Not Eligible: _____

Medicare	County	LIS (lvl/%)	COB	Emp Sub	Group Number	Pkg/PBP
A _____			Y N	Y N		
B _____	ESRD	PW	EPIC	CC	# Uncovered Months	Plan
D _____	Y N	D S	Y N	Y N	From _____ To _____	H3351, H3335