2014 Individual Enrollment Request Form

Blue Shield 65 Plus (HMO) and Blue Shield 65 Plus Choice Plan (HMO)

Please contact Blue Shield of California if you need information in another language or format (Braille).

Please fax or mail your completed enrollment form to:

Fax: (877) 251-3660
Mail: Blue Shield of California
P.O. Box 948, Woodland Hills, CA 91365-9856

To enroll in Blue Shield 65 Plus℠ or Blue Shield 65 Plus Choice Plan, please provide the following information:

Please check which plan you want to enroll in, based on where you live:

- ☐ Los Angeles*/Orange counties ($0 per month)
- ☐ Choice Plan (Los Angeles*/Orange counties) ($0 per month)
- ☐ Contra Costa* County ($0 per month)
- ☐ Fresno County ($0 per month)
- ☐ Riverside* County ($0 per month)
- ☐ Sacramento* County ($0 per month)
- ☐ San Bernardino* County ($0 per month)
- ☐ Santa Clara* County ($0 per month)
- ☐ San Diego County ($0 per month)
- ☐ Ventura* County ($0 per month)

*See your Summary of Benefits for covered ZIP codes.

Please indicate if you would like to enroll in the Optional Supplemental Dental HMO Plan

☐ Optional Dental HMO plan ($12.20 per month)

Name of dentist _____ Provider ID# _____

If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

☐ Mr. ☐ Mrs. ☐ Ms.	Last name	First name	Middle initial

Birth date (__ __/__ __/__ __ __ __) (MM / DD / Y Y Y Y)	Sex ☐ M ☐ F	Home phone number ( )

Permanent residence street address (no P.O. boxes)

Street	City	State	ZIP code

Mailing address (only if different from your permanent residence address)

Street	P.O. Box	City	State	ZIP code

Emergency contact	Relationship to you	Phone number ( )

Email address

☐ I am willing to receive required plan materials via email (i.e., enrollment notifications, the Annual Notice of Change, and plan newsletter) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

H0504_13_175 CMS Approved 09092013

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.

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

__ __ __-__ __ -__ __ __ __

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), or if you enroll in the Optional Supplemental Dental HMO Plan, we need to know how you would prefer to pay it.

You can pay by mail or by "Electronic Funds Transfer (EFT)" each month. You can also choose to pay 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 the RRB. DO NOT pay Blue Shield of California 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 co-insurance. 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 late enrollment penalty/optional supplemental dental HMO plan premium payment payment option:

☐ Get a monthly 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.)

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 anymore, **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, Workers' Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan? ☐ Yes ☐ No

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

Prescription drug coverage

Name of other coverage	ID No. for this coverage	Group No.

Medical coverage

Name of other coverage	ID No. for this coverage	Group No.

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 and phone number of Institution (number and street) _____

_____

4. Are you enrolled in your State Medicaid program (Medi-Cal)? ☐ Yes ☐ No

If yes, please provide your Medicaid (Medi-Cal) number _____

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

Primary Care Physician

Please choose a primary care physician.

Your physician choice _____

Physician ID No. _____ Current patient ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ☐ Spanish ☐ Large Print

Please contact Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan at **(800) 776-4466** [TTY users should call **(800) 794-1099**] if you need information in a format or language other than what is listed above. Our office hours are 7 a.m. to 8 p.m., seven days a week, from October 1 through February 14. However, after February 14, your call will be handled by our automated phone system on weekends and holidays.

Please read this important information

If you currently have health coverage from an employer or union, joining Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan. 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 Shield 65 Plus and Blue Shield 65 Plus Choice Plan are Medicare Advantage plans and have 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: October 15 - December 7 of every year), or under certain special circumstances.

Blue Shield 65 Plus and Blue Shield 65 Plus Choice Plan serve a specific service area. If I move out of the area that Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan serve, 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 Shield 65 Plus or Blue Shield 65 Plus Choice Plan, 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 Shield 65 Plus or Blue Shield 65 Plus Choice Plan 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 Shield 65 Plus or Blue Shield 65 Plus Choice Plan coverage begins, I must get all of my health care from Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized

by Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan and other services contained in my Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS OR BLUE SHIELD 65 PLUS CHOICE PLAN 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 Shield, he/she may be paid based on my enrollment in Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan.

Release of information: By joining this Medicare health plan, I acknowledge that Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California 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 legally authorized representative (i.e., power of attorney or legal guardian – see description above), you must sign above and provide the following information:

Name _____ Address _____

Phone number (_____) _____ – _____ Relationship to enrollee _____

Producer information:

TMO/GMO/Other name _____ TMO/GMO/Other ID No. _____
(Please print name)

Producer name Rick Plata Producer ID No. 8728857
(Please print name)

Producer phone number (888) 235 – 8060

Producer email address advisorrick@msn.com

Date application received by producer _____

Producer signature _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete pre-sale kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. 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 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 qualifications required to be in the 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 Shield Member Services at **(800) 776-4466** (TTY users should call **(800) 794-1099**) to see if you are eligible to enroll. We are open 7 a.m. to 8 p.m., seven days a week, from October 1 through February 14. However, after February 14, your call will be handled by our automated phone system on weekends and holidays.

Office use only:

Name of staff member (if assisted enrollment) Rick Plata 8728857
(Please print name)

Plan ID No. _____ Effective date of coverage _____ ICEP/IEP _____

AEP _____ SEP (type) _____ Not eligible _____ NIPR No. _____

Please mail your completed form to:

Medicare Options

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060.