

2012 Individual Enrollment Form

Blue Shield Medicare Basic Plan (PDP), Blue Shield Medicare Enhanced Plan (PDP), and Blue Shield Medicare Premium Plan (PDP)

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

To enroll in a Blue Shield Medicare prescription drug plan, please provide the following information:

Please check which plan you want to enroll in

- Blue Shield Medicare Basic Plan (PDP) (\$41.10 per month)
- Blue Shield Medicare Enhanced Plan (PDP) (\$55.60 per month)
- Blue Shield Medicare Premium Plan (PDP) (\$108.20 per month)

| | | | |
|--|-----------|---|----------------|
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. | Last name | First name | Middle initial |
| Birth date (MM/DD/YYYY) (__/__/____) | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | |
| Home phone number () | | E-mail address | |

| |
|--|
| <input type="checkbox"/> I am willing to receive required plan materials via e-mail (i.e., the Annual Notice of Change and plan newsletter) in place of mailed printed copies. |
| <input type="checkbox"/> I am willing to receive non-required materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies. |

You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

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

| | | | |
|--------|------|-------|----------|
| Street | City | State | ZIP code |
|--------|------|-------|----------|

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

| | | | |
|--------|------|-------|----------|
| Street | City | State | ZIP code |
|--------|------|-------|----------|

| | | |
|-------------------|---------------------|---------------------|
| Emergency contact | Relationship to you | Phone number () |
|-------------------|---------------------|---------------------|

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 or Part B (or both) to join a Medicare prescription drug plan.

Paying your plan premium

You can pay your Medicare drug plan directly for your monthly plan premium (including any late enrollment penalty you may owe), or have the monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board benefit check each month. If you choose to pay directly, you can pay by mail or by automatic check draft (ACH) 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Blue Shield.


People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a 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 receive a bill each month.

Please select a plan premium payment option:

- Receive a monthly statement and pay by mail.
- Automatic check draft (ACH) from your bank account each month. Please fill out the Blue Shield Medicare Prescription Drug Plan Easy\$PaySM form. You will receive this form as part of your new-member welcome kit once you enroll in our plan.
- Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check may include all plan premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please do not send payment or an Easy\$Pay form with this application.

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

Please answer the following questions

1. Some individuals may have other drug coverage, including other private insurance, coverage through their former employer/union, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to the Blue Shield Medicare prescription drug plan that you are enrolling in?

Yes No

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

Name of other coverage _____

ID No. for this coverage _____

Group No. for this coverage _____

2. 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)

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 at **(888) 239-6469** [TTY users should call (888) 239-6482] if you need information about a Blue Shield Medicare prescription drug plan 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.



Please read this important information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining a Blue Shield Medicare prescription drug plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining a Blue Shield Medicare prescription drug plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Blue Shield Medicare prescription drug 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 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 Medicare Basic Plan (PDP), Blue Shield Medicare Enhanced Plan (PDP), and Blue Shield Medicare Premium Plan (PDP) are Medicare drug plans and have a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform my Blue Shield Medicare prescription drug plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in a Blue Shield Medicare prescription drug plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Blue Shield Medicare prescription drug plans serve a specific service area. If I move out of the area that Blue Shield Medicare prescription drug plans serve, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue Shield's Medicare prescription drug plan network pharmacies. Once I am a member of a Blue Shield Medicare prescription drug 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 Medicare Basic Plan (PDP), Blue Shield Medicare Enhanced Plan (PDP), or Blue Shield Medicare Premium Plan (PDP) when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

If we determine that you owe a late enrollment penalty, you will have to pay the late enrollment penalty to us in addition to your monthly premium.

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

Release of information: By joining this Medicare prescription drug plan I acknowledge that the Blue Shield Medicare Basic Plan (PDP), Blue Shield Medicare Enhanced Plan (PDP), or Blue Shield Medicare Premium Plan (PDP) will release my information to Medicare or other plans as 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 State law 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.

Signature

Today's date

If you are the 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 (for producer use only):

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

Producer phone number (888) 235 – 8060 Producer signature _____

Date application received by producer: _____

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.

Medicare Prescription Drug Plan use only:

Plan ID No. _____ Effective date of coverage _____

IEP _____ AEP _____ SEP (type) _____ NIPR# _____

Plan representative signature/Name _____
(Please print name)

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.