Individual Enrollment Request Form

for Medicare Advantage

BlueCross BlueShield Kansas

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

Section 1 – To enroll, please provide the following information.

Please check which plan you want to enroll in:

☐ Blue Medicare Advantage (PPO) – $0 per month

☐ Blue Medicare Advantage Choice (PPO) – $0 per month

☐ Blue Medicare Advantage Comprehensive (PPO) – $50 per month

Available in the following counties:

- Chase
- Coffey
- Douglas
- Franklin
- Geary
- Jackson
- Jefferson
- Linn
- Lyon
- Miami
- Morris
- Osage
- Pottawatomie
- Riley
- Shawnee
- Wabaunsee

First Name _____ MI _____

Last Name _____ Suffix _____

Gender ☐ Male ☐ Female

_____ / _____ / _____
Date of Birth

(_____) _____-_____
Home Phone Number

(_____) _____-_____
Alternate Phone Number

_____
Email Address (optional)

Permanent Residence Street Address (P.O. Box not allowed) _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Mailing Address (if different from Permanent Residence Address) _____

City _____

State _____ ZIP Code _____ +4 _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Blue Cross and Blue Shield of Kansas is a PPO plan with a Medicare contract.
Enrollment in Blue Cross and Blue Shield of Kansas depends on contract renewal.

Section 2 – Race and Ethnicity

Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a or of Spanish origin?
Select all that apply.

- ☐ No, not of Hispanic, Latino/a or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a or Spanish origin
- ☐ Yes, Mexican, Mexican-American, Chicano/a
- ☐ Yes, Cuban
- ☐ I choose not to answer

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer

Section 3 – Please provide your Medicare insurance information.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Note: You must have Medicare Part A and Part B to join a Medicare Advantage plan.

_____
Name (as it appears on your Medicare card)

_____
Medicare Number

Hospital (Part A) Effective Date _____ / _____ / _____

Medical (Part B) Effective Date _____ / _____ / _____

Please continue on the next page.

For Medicare Advantage Prescription Drug plans with no premiums: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium 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 Cross and Blue Shield of Kansas the Part D-IRMAA.

For Medicare Advantage Prescription Drug plans with premiums: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium 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 RRB. DO NOT pay Blue Cross and Blue Shield of Kansas 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 800-772-1213. TTY users should call 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 continue on the next page.

Section 4a – Please select a premium payment option.

☐ Get a monthly bill.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a **voided** check or provide the following information:

_____
Account Holder Name

_____ _____
Bank Routing Number Bank Account Number

Account Type: ☐ Checking ☐ Savings

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.

Section 5 – Optional Supplemental Enrollment

For an additional $21 per month, members can purchase optional comprehensive dental buy-up. **This option is only available to Blue Medicare Advantage (PPO) and Blue Medicare Advantage Comprehensive (PPO) plans.**

☐ **I wish to add the optional comprehensive dental** to my current plan at the cost of $21 per month.

Section 6 – Please read and answer these important questions.

Yes No

☐ ☐ 1. Will you have other prescription drug coverage in addition to Blue Cross and Blue Shield of Kansas? For example, other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

_____
Name of other coverage

_____ _____
ID Number for this coverage Group Number for this coverage

☐ ☐ 2. Are you a resident in a long-term care facility, such as a nursing home?
If yes, please provide the following information:

_____ (_____) _____-_____
Name of Institution Phone Number of Institution

_____
Address of Institution (Number and Street)

☐ ☐ 3. Are you enrolled in your State Medicaid program?

If yes, please provide your Medicaid number: _____

☐ ☐ 4. Do you work?

☐ ☐ 5. Does your spouse work?

Please continue on the next page.

Section 7 – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual open 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. (NEW)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). (OEP)

☐ 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 _____ / _____ / _____. (MOV)

☐ I recently was released from incarceration. I was released on _____ / _____ / _____. (INC)

☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ / _____ / _____. (RUS)

☐ I recently obtained lawful presence status in the U.S. I got this status on _____ / _____ / _____. (LAW)

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____ / _____ / _____. (MCD)

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on _____ / _____ / _____. (NLS)

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. (MDE)

☐ 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 _____ / _____ / _____. (LTC)

☐ I recently left a PACE program on _____ / _____ / _____. (PAC)

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ / _____ / _____. (LCC)

☐ I am leaving employer or union coverage on _____ / _____ / _____. (LEC)

☐ I belong to a pharmacy assistance program provided by my state. (PAP)

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. (EOC)

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on _____ / _____ / _____. (DIF)

Please continue on the next page.

Section 8 – Attestation of Eligibility for an Enrollment Period (continued)

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ____ / ____ / ____. (SNP)

☐ I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA). (DST)

☐ None of these statements apply to me. (OTH)
Other Special Enrollment Period (SEP) reason:

_____

If none of these statements applies to you or you're not sure, please contact Blue Cross and Blue Shield of Kansas at 800-752-6650 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1 through March 31, Monday through Sunday, 8 a.m. to 8 p.m.; and April 1 through September 30, Monday through Friday, 8 a.m. to 8 p.m.

Section 9 – (Optional) Please enter your Primary Care Provider (PCP) information.

Physician Name	City		
Street Address	State	ZIP Code	+4

Section 10 – Information Preferences

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format.

Please send me information in the following language(s):

☐ Spanish

Please send me materials in another format:

☐ Braille ☐ Large print ☐ Audio tape

Please contact Blue Cross and Blue Shield of Kansas at 800-752-6650 (TTY:711) if you need information in an accessible format or language other than what is listed above. We are open October 1 through March 31, Monday through Sunday, 8 a.m. to 8 p.m.; and April 1 through September 30, Monday through Friday, 8 a.m. to 8 p.m.

Section 11 – **STOP!** Please read this important information.

If you currently have health coverage from an employer or union, joining Blue Cross and Blue Shield of Kansas could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross and Blue Shield of Kansas.

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 continue on the next page.

Section 12 – Please read and sign below.

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

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Cross.
- By joining this Medicare Advantage, I acknowledge that Blue Cross will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Blue Cross coverage begins, I must get all of my medical and prescription drug benefits from Blue Cross. Benefits and services provided by Blue Cross and contained in my Blue Cross "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Cross will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Your signature required

_____ _____ / _____ / _____

Applicant (Signature of authorized representative if other than applicant) Date Signed

If you are the authorized representative, you must sign above and provide the following information:

_____ _____

Print Name Street Address

(_____) _____-_____ _____ _____ _____ _____

Phone Number Relationship To Enrollee City State ZIP Code

_____

Email Address

Office Use Only

_____ Effective Date of Coverage _____ / _____ / _____

Name of Staff Member/Agent/Broker (if assisted in enrollment)

_____ _____ _____ _____ _____ _____

Agent Code Plan ID Number ICEP/IEP AEP SEP (type) Not Eligible