Completing your Medicare Advantage enrollment application

We're here to help.

» Need help completing your application?

» Have questions?

» Want more information?

Please call us at 800-354-9387 (TTY 711). Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on Thanksgiving, Christmas, and holidays and weekends from April 1 through September 30. Please leave a message and your call will be returned the next business day. Customer Service also has free language interpreter services available for non-English speakers.

Ready to enroll?

Enroll online at **bcbsks.com/medicare**

Call us at 800-354-9387 (TTY 711)

Or **Enroll using this form**. Here are some helpful hints:

» Use a blue or black ink pen

» Complete a separate form for each person enrolling

» Print your answers, except where you signature is required

» Make sure you complete each section of the application

» Mail your application promptly

Please do not send your payment with this application.

Return the completed form in the postage-paid envelope, or mail it to:

BCBSKS Enrollment Application Processing
PO Box 260767
Plano, TX 75026-0767

What happens next?

» Once the Centers for Medicare & Medicaid Services (CMS) approves your application, we'll send you a letter within 10 days, confirming your enrollment.

» We'll bill you based on your plan choice or automatically deduct your premium from your Social Security check, if you choose that option.

» You'll also receive an information packet about the benefits you get with your plan coverage.

An independent licensee of the Blue Cross Blue Shield Association.

Individual Enrollment Request Form

for Medicare Advantage

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 Comprehensive (PPO) – $50 per month

Available in the following counties:

- » Douglas
- » Jackson
- » Jefferson
- » Osage
- » Pottawatomie
- » 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-NEW. 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 OM viewed, or forwarded to the plan. See "What happens next?" on the cover 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.

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Please continue on the next page.

Section 2 – 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 ____ /____ /______

Section 3 – Paying your plan premium

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 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.

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.

Please continue on the next page.

Section 3a – 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 4 – Optional Supplemental Enrollment

For an additional $21 per month, members can purchase optional comprehensive dental buy-up.

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

Section 5 – Please read and answer these important questions.

Yes No

☐ ☐ 1. 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 Blue Cross and Blue Shield of Kansas?
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 6 – 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 6 – 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 7 – (Optional) Please enter your Primary Care Provider (PCP) information.

Physician Name	City
Street Address	State / ZIP Code / +4

Section 8 – 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 9 – **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 10 – Please read and sign below.

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

Blue Cross and Blue Shield of Kansas (Blue Cross) 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 be in only 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: Annual Enrollment Period October 15 – December 7 or MA Open Enrollment Period January 1 – March 31), or under certain special circumstances.

Blue Cross serves a specific service area. If I move out of the area that Blue Cross 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 Blue Cross, I have the right to appeal plan decisions about payment or services if I disagree. I will read either the Member Handbook or Evidence of Coverage document from Blue Cross 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 Cross coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Blue Cross provides refunds for all covered benefits, even if I get services out of network. Services authorized by Blue Cross and other services contained in my Blue Cross Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Blue Cross 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 Cross, he/she may be paid based on my enrollment in Blue Cross.

Release of Information: By joining this Medicare health plan, I acknowledge that Blue Cross will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross 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.

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

Office Use Only

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

Effective Date of Coverage _____ /_____ /________

__________ Agent Code

______________________________ Plan ID Number

__________ ICEP/IEP

__________ AEP

__________ SEP (type)

__________ Not Eligible