**Medicare PLUS Blue PPO℠**

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Medicare Plus Blue PPO is a health plan with a Medicare contract.

# 2010

## INDIVIDUAL ENROLLMENT FORM

## Medical and Prescription Drug Coverage (Coverage Effective 2010)

**Office Use Only:**

**Please contact Medicare Plus Blue PPO if you need information in another language or Braille.**
**Do not send a payment with this application. You will be billed at a later date.**

### Sec. I To enroll in Medicare Plus Blue PPO, please provide the following information:

**Check the appropriate region: (See premium table on other side of this form.)**
**Note:** "If your permanent address is in one of the following counties, you're not eligible to enroll in Medicare Plus Blue PPO: **Antrim, Benzie, Charlevoix, Cheboygan, Emmet, Grand Traverse, Kalkaska or Leelanau."**

| Region (See counties on Premium Table) | Premium Amount | Region (See counties on Premium Table) | Premium Amount |
|---|---|---|---|
| **Region 1: Southwest Michigan** | ☐ **$61** | **Region 4: South Michigan** | ☐ **$121** |
| **Region 2: Mid-Michigan** | ☐ **$91** | **Region 5: North/East Michigan** | ☐ **$141** |
| **Region 3: Upper Michigan** | ☐ **$131** | **Region 6: Southeast Michigan** | ☐ **$141** |

☐ Mr. ☐ Mrs. ☐ Ms.

First Name | Middle Initial | Last Name

Birth Date ( / / ) (M M / D D / Y Y Y Y)

Sex ☐ Male ☐ Female

Home Phone Number ( )

Alternate Phone Number ( )

E-mail Address (Providing e-mail address allows for future communications)

Permanent Residence Street Address (No P.O. Box)

City | State | Zip Code | County

**Mailing Address** (Only if different from your permanent residence street address)

Street Address ______ City ______ State ____ Zip Code ______

**OPTIONAL INFORMATION**

**Emergency Contact Name** ______

**Relationship to You** ______ **Phone Number** ( ) ______

### Sec. II 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 the Social Security Administration or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ______

Medicare Claim Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Sex ☐ M ☐ F

Is Entitled To: | Effective Date

**HOSPITAL (Part A)** ______

**MEDICAL (Part B)** ______

**Mail-White Copy Keep-Yellow Copy**

## Sec. III — Information to determine enrollment periods

**Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can also join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.**

**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 dissenrolled.**

☐ 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. Date of Move:_ _ / _ _ / _ _ _ _
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
☐ I recently "left" a PACE program. 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). Effective Date: _ _ /_ _ /_ _ _ _
☐ I recently involuntarily lost my credible drug coverage (coverage as good as Medicare's). Date of Loss: _ _ / _ _ / _ _ _ _
☐ I am leaving employer or union coverage. Effective Date: _ _ / _ _ / _ _ _ _
☐ I belong to a pharmacy assistance program provided by my state.
☐ I recently returned to the United States after living permanently outside of the U.S. Date of Return: _ _ / _ _ / _ _ _ _
☐ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan for the first time (*Medicare Advantage plan with prescription drug coverage).
☐ In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
☐ I am currently receiving extra help paying for Medicare prescription drug coverage but do not have Medicaid.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. Effective Date: _ _ / _ _ / _ _ _ _
☐ My plan is ending its contract with Medicare. Effective Date: _ _ / _ _ / _ _ _ _
☐ I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
☐ I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.
☐ I received a notice from my plan or Medicare telling me that I am eligible for a Special Enrollment Period.
☐ I get extra help paying for Medicare prescription drug coverage.
☐ I am eligible to join or leave a Medicare Advantage Plan. Note: Open Enrollment Period only Effective Date: _ _ / _ _ / _ _ _ _
☐ Other Reason provided to me by a Medicare Official: ______________________________
☐ None of these statements applies to me.*

* Please contact Medicare Plus Blue PPO at 800-485-4415 (TTY users should call 800-481-8704) to see if you are eligible to enroll. We are open seven days a week, from 8 AM to 8 PM.

## Sec. IV — Paying your plan premium

You can pay your monthly plan premium by mail or automatic withdrawal from your bank account each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month. 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 socialsecurity.gov/prescriptionhelp.

## Sec. IV Continued — Paying your plan premium

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 premium payment option. Check **only one** box.

☐ **1)** Bill me on a monthly basis.

☐ **2)** Automatic deduction from my monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

☐ **3)** Electronic funds transfer (EFT) from my bank account each month. Please enclose a VOIDED check or savings deposit slip and provide the following:

Account Holder Name:______________________________

Bank Routing Number: _ _ _ _ _ _ _ _ _ Bank Account Number:______________________________

Account Type: ☐ Checking ☐ Savings

## Sec. V — Please read and answer the following important questions

**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 Medicare Plus Blue PPO? ☐ 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 you answered "yes", please provide the following information.

| Name of Facility | | | |
|---|---|---|---|
| Address | | | |
| City | State | Zip Code | Phone Number |

**3.** Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant to:

Medicare Plus Blue PPO
P.O. Box 3817, Southfield, MI 48037-3817

**Note:** If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Blue Cross Blue Shield of Michigan organization as a commercial member or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998.

**4.** Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

If you answered "yes", please provide your Medicaid Number: ______________________________

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

## Sec. VI Please read and answer if needed

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: ☐ Spanish ☐ Braille

Please contact Medicare Plus Blue PPO at 800-485-4415 (TTY users should call 800-481-8704) if you need information in another format or language than what is listed above. Our office hours are seven days a week, from 8 AM to 8 PM.

**Agent/Office Use Only: (Applicant does not need to complete this section).**

**Note to Agents:** 2010 paper enrollment forms must be keyed into **bcbsm.com/agent/** or submitted to the Managing or General Agent within 24 hours of accepting the paper enrollment form.

**Date Producing Agent accepted paper enrollment from Medicare Eligible:** ☐☐/☐☐/☐☐☐☐

**Date Managing or General Agent or Association received paper enrollment form from Producing Agent:** ☐☐/☐☐/☐☐☐☐

Name of Managing or General Agent or Association **(print)**: ____________________

Name of Producing Agent (**print** first, last name): ____________________

Signature of Producing Agent: ____________________

**2-digit Managing or General Agent or Association Code:** ☐☐ **5-digit Producing Agent Code:** ☐☐☐☐☐

I assisted the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of *person entering enrollment information online* (**print** first, last name): ____________________

BCBSM Source Code: ☐ BCBSM Badge # : E☐☐☐☐☐☐

## Sec. VII Please read this important information.

**If you currently have health coverage from an employer or union, joining Medicare Plus Blue PPO could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join Medicare Plus Blue PPO. 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 admistrator or the office that answers questions about your coverage can help. Once Medicare Plus Blue PPO has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a preferred provider organization plan works and to confirm your intent to enroll in Medicare Plus Blue PPO. If Medicare Plus Blue PPO isn't able to reach you by phone, then you will get a letter by mail that contains similar information.

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

Medicare Plus Blue PPO 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: November 15 – December 31 of every year), or under certain special circumstances.

**Sec. VII Continued** **Please read this important information.**

Medicare Plus Blue PPO serves a specific service area. If I move out of the area that Medicare Plus Blue PPO 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 Medicare Plus Blue PPO I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medicare Plus Blue PPO 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 Medicare Plus Blue PPO 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, Medicare Plus Blue PPO provides refunds for all covered benefits, even if I get services out of network." Services authorized by Medicare Plus Blue PPO and other services contained in my Medicare Plus Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Medicare Plus Blue PPO 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 Medicare Plus Blue PPO, he/she may be paid based on my enrollment in Medicare Plus Blue PPO.

**Sec. VIII** **Please read and sign below**

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

| Your Signature | | | Today's Date |
|---|---|---|---|
| If you are the authorized representative, you must provide the following information | | | |
| Name | | | Phone Number ( ) |
| Address | City | State | Zip Code |
| Relationship to Enrollee | | | |

**Please mail this form to:** **Medicare Plus Blue PPO**
**PO Box 3817**
**Southfield, MI 48037-3817**

# Medicare Plus Blue PPO Premium Table

**The premiums vary by the county in which you permanently reside**
**(Rates are based on the use and cost of health care services in each region)**

1. **Locate the region and county in which you permanently reside.**
2. **Determine your monthly premium rate.**
3. **Check the correct option box on the first page of this application.**
   (Only one box may be checked.)

| Medical and Prescription Drug Coverage | Monthly Medicare Plus Blue PPO Premium |
|---|---|
| **Region with counties** | |
| **Region 1: Southwest Michigan**<br>Allegan, Kent, Muskegon, Newaygo, Ottawa | **$61** |
| **Region 2: Mid-Michigan**<br>Barry, Berrien, Cass, Clinton, Eaton, Ingham, Ionia, Kalamazoo, Van Buren | **$91** |
| **Region 3: Upper Michigan**<br>Alcona, Alger, Alpena, Baraga, Chippewa, Crawford, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Montmorency, Ontonagon, Oscoda, Otsego, Presque Isle, Schoolcraft | **$131** |
| **Region 4: South Michigan**<br>Branch, Calhoun, Hillsdale, Jackson, Lenawee, Livingston, Monroe, St Joseph, Washtenaw | **$121** |
| **Region 5: North/East Michigan**<br>Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Iosco, Isabella, Lake, Lapeer, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Oceana, Ogemaw, Osceola, Roscommon, Saginaw, Saint Clair, Sanilac, Shiawassee, Tuscola, Wexford | **$141** |
| **Region 6: Southeast Michigan**<br>Macomb, Oakland, Wayne | **$141** |