Prescription Blue℠ PDP 2026 Individual Enrollment Form

Prescription Blue℠ PDP

Blue Cross Blue Shield of Michigan

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare or 3 months prior
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Prescription Blue PDP
P.O. Box 44828
Detroit, MI 48244-0828

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Prescription Blue at **1-833-844-3871**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Prescription Blue al **1-833-844-3871 / 711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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Section 1 – All fields in this section are required (unless marked optional)

Select the PDP plan you want to join:

☐ **Select – $78.40 per month** ☐ **Premium – $106.70 per month**

First name	Last name	(Optional) Middle initial
Birth date (mm/dd/yyyy)	Sex ☐ M ☐ F	Phone number

Permanent residence street address (Don't enter a PO Box. **Note:** For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

City	(Optional) County	State	ZIP code

Mailing address, if different from your permanent address (PO Box allowed)

Street address	City	State	ZIP code

Email address (optional)

Your Medicare information

Medicare number: __ __ __ __ – __ __ __ – __ __ __ __

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Prescription Blue?

☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage _____

Special enrollment periods: Please check the box that applies to you.

Typically, you may enroll in a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the annual enrollment 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'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (Date of Medicare Entitlement Letter) _____.
- ☐ I had Medicare prior to now, but I'm now turning 65.
- ☐ Between 1/1-3/31: I'm in a Medicare Advantage Plan and want to make a change.
- ☐ Between 4/1-12/31: I'm in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date). _____.
- ☐ I recently was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ 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 (insert date) _____.
- ☐ I am moving into a long-term care facility, like a nursing home or rehabilitation hospital. I will move into the facility on (insert date) _____.
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital. I moved 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

Special enrollment periods *(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 (insert date) _____.
- ☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan. My plan went into receivership on (insert date) _____.
- ☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- ☐ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ☐ I lost my Medicare Advantage Plan with drug coverage because I lost Medical (Part B) coverage. I want to join a Medicare drug plan.
- ☐ I dropped my Cost Plan with drug coverage and switched to Original Medicare. I want to join a Medicare drug plan.
- ☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare Drug Plan (Part D) or Medicare Advantage Plan with drug coverage.
- ☐ I signed up for a Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare drug plan (Part D).
- ☐ I dropped a Medicare Supplement Insurance (Medigap) policy when I first joined a Medicare Advantage Plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I'm joining a Drug Plan (Part D).
- ☐ I joined a Medicare Advantage Plan with drug coverage when I turned 65. It's been less than 12 months since I joined this plan. I want to switch to Original Medicare, and I'm joining a Drug Plan.
- ☐ I have Medicare and Medicaid, or I get Extra Help paying for Medicare drug costs. I want to switch to a different Medicare drug plan.
- ☐ I have Medicare and Medicaid, or I get Extra Help paying for Medicare drug coverage. I want to drop my Medicare Advantage Plan with drug coverage and return to Original Medicare and join a separate Medicare drug plan.
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ Other

If none of these statements applies to you or you're not sure, please contact Prescription Blue at **1-833-844-3871** (TTY users should call **711**) to see if you are eligible to enroll. We are open from 8 a.m. to 9 p.m. Eastern time Monday through Friday, with weekend hours Oct. 1 through March 31.

IMPORTANT: Read and sign below

- I must keep Hospital (Part A) or Medical (Part B) to stay in Prescription Blue.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Prescription Blue 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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.

Signature	**Today's date**

If you're the authorized representative, sign above and fill out these fields:

Name	Address
Phone number	Relationship to enrollee

Section 2 – All fields in this section are optional

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

Select one if you want us to send you information in a language other than English.

☐ English (default) ☐ Spanish ☐ Other (language other than English)

Select one if you want us to send you information in an accessible format.

☐ Large print ☐ Audio CD ☐ Data CD

Please call Prescription Blue PDP at **1-800-565-1770** (TTY users, call **711**) if you need information in an accessible format or language other than what's listed above. Our office hours are from 8 a.m. to 9 p.m. Monday through Friday, with weekend hours from October 1 through March 31.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or automatic withdrawal from your bank account each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month**.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare or the RRB. DON'T pay Prescription Blue PDP the Part D-IRMAA.

Please select a premium payment option:

☐ Get a bill each month.

You may choose from the following payment methods:

- **Pay online:** To learn how to pay your premium online, go to **bcbsm.com/paymedicare**. Members can make one-time payments or set up automatic withdrawals from a bank account or credit/debit card.
- **Pay by phone:** To make a one-time payment or set up an automatic withdrawal from a bank account or credit/debit card, call Customer Service at **1-800-565-1770**, from 8 a.m. to 9 p.m. Eastern time Monday through Friday, with weekend hours from October 1 through March 31. TTY users call **711**.
- **Pay by mail:** Mail your check, cashier's check or money order made payable to:
  Blue Cross Blue Shield of Michigan
  P.O. Box 553912
  Detroit, Michigan 48255-3912

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or the RRB approves the deduction. Please pay any premium bills prior to your Social Security/Railroad Retirement Board deduction effective date. If Social Security/the RRB doesn't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums.)

For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agent, broker, SHIP counselor, family member or other third party) helping an enrollee fill out this form.	
Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

AGENT/OFFICE USE ONLY (Applicants do not complete this section)

Note to producing agents: Paper enrollment forms must be keyed in by logging into the BCBSM Agent Portal at **bcbsm.com/agents/** or submitted to the 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/general agent or association: _____

Name of producing agent (print first/last names): _____

First name *Last name*

Signature of producing agent: _____

Email of producing agent: _____

2-digit managing or general agent or association code: ___/___/

5-digit producing agent code: ___/___/___/___/___

I helped 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 names):

_____

First name *Last name*

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 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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.