Blue Medicare Advantage (HMO)

Individual Enrollment Form Instructions

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Please complete the application using black ballpoint pen, and press firmly.
All sections must be filled out in full and all pages faxed.

Blue Medicare Advantage (HMO)

Individual Enrollment Request Form

BlueCross BlueShield Arizona

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To enroll, please provide all the information requested below.

REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

Maricopa County and Pinal County

☐ Blue Medicare Advantage Classic (HMO)
$0 monthly premium (H0302-006)

☐ Blue Medicare Advantage Plus (HMO)
$48 monthly premium (H0302-001)

Pima County

☐ Blue Medicare Advantage Classic (HMO)
$0 monthly premium (H0302-008)

Santa Cruz County

☐ Blue Medicare Advantage Standard (HMO)
$0 monthly premium (H0302-009)

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.

Name: Jane L. Smith
(as it appears on your Medicare card)

Medicare Number X X X X - X X X - X X X X

Is Entitled To — Effective Date (MM/DD/YYYY)
HOSPITAL (Part A) 01/01/2000
MEDICAL (Part B) 01/01/2000

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

LAST Name: Smith	FIRST Name: Jane	Middle Initial: L.	☐ Mr. ☒ Mrs. ☐ Ms.
Birth Date: 06/03/1933 (MM/DD/YYYY)	Sex: ☐ M ☒ F	Phone Number: (602) 000-0000	
Permanent Residence Street Address (P.O. Box is not allowed): 1234 West Street			Apt. #: 203
City: Phoenix	State: Arizona		ZIP Code: 85000
County: Maricopa	Email Address¥: jane.smith@yahoo.com		
Mailing Address (only if different from your Permanent Residence Address): P.O. Box 56789			Apt. #:
City: Phoenix	State: Arizona		ZIP Code: 85000
Alternate Contact: Robert Smith	Phone Number: (602) 000-0000		Relationship to you: Brother

Please choose the name of a Primary Care Provider (PCP): _____
(FIRST Name) *(LAST Name)*

Is this your current Primary Care Provider? ☐ Yes ☐ No
Please note: if you do not provide the name of a PCP, one will be assigned for you by the plan.

Have you recently moved into the service area for the plan you selected above? ☐ Yes ☐ No
If yes, Date of Move _____/_____/_____

STEPS:

A. Select the plan you wish to enroll in.

B. Provide your Medicare Insurance Information as it appears on your red, white, and blue Medicare I.D. card.

C. Provide all personal information.

D. The person to contact if we are unable to contact you.

E. Provide the name of your Primary Care Provider (PCP). Without this information, your PCP will be automatically assigned for you by the plan.

¥By providing this email address, I agree to receive email communications from Blue Cross Blue Shield of Arizona Advantage (e.g., certain plan documents and health education materials).

*Our service area includes all of Maricopa, Pima, Santa Cruz, and Pinal counties.

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YOUR CHECK LIST

Please read the instructions and statements carefully. Please use this check list to make sure you've completed all required information.

☐ **A. WHICH PLAN ARE YOU ENROLLING IN?** – Mark an "X" in the box next to the Blue Cross Blue Shield of Arizona Advantage (BCBSAZ Advantage) Health Plan you wish to enroll in.

☐ **B. MEDICARE NUMBER** – Please print your Medicare Number exactly as it is written on your Medicare Health Insurance Card or your letter from Social Security or the Railroad Retirement Board.

☐ **C. PERSONAL INFORMATION** –

- **Name** – print your name exactly as it appears on your Medicare Health Insurance Card, even if there is an error. Errors need to be corrected with your local Social Security Administration Office. We will be notified of your corrected name by the Centers for Medicare and Medicaid Services (CMS).
- **Permanent Street Address** - should be your current residence, where you presently live (P.O. Box Address is NOT allowed). You must live within the BCBSAZ Advantage service area to join this plan.
- **Mailing Address** *(if different from your Permanent Residence)* – an address where you receive your mail.

☐ **D. ALTERNATE CONTACT** – Provide the name of a friend or relative, who does not reside with you, as an alternate contact should we be unable to reach you.

☐ **E. PRIMARY CARE PROVIDER** – Please print the First and Last Name of your Primary Care Provider (PCP). If you do not complete this information, your PCP will be automatically assigned for you by the plan.

IMPORTANT INFORMATION – Read each statement carefully. If there is anything you do not understand, please contact BCBSAZ Advantage at the phone number below, during the hours of operations listed below.

SIGNATURE – By signing your enrollment form, you agree to follow the plan rules and have an understanding of your member responsibilities. If you have any questions, please call us. **Sign your name as it is listed on your Medicare Health Insurance Card, and date the form.** Keep the Enrollment Receipt of the enrollment form for your records. In most cases, we will acknowledge the receipt of your application in writing before the effective date. If someone is assisting you in completing this form, please contact BCBSAZ Advantage at the telephone numbers listed below for further instructions. If you have a representative that is completing this form on your behalf, your representative must be a Durable General Power of Attorney (DPOA) or court-ordered Legal Guardian to sign this form. Please provide a copy of the paperwork that shows that your representative is your DPOA or Legal Guardian. Lack of proof will not delay the processing of the application.

Mail the Individual Enrollment Form to:
Blue Cross Blue Shield of Arizona
13985 W. Grand Ave., Ste. 200, Surprise, AZ 85374

Contact us at:
1-888-274-0367, TTY: 711
We are available October 1 – March 31, seven days a week, 8 a.m. to 8 p.m.
(April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m.)
Or, visit our website at azbluemedicare.com

BCBSAZ offers BluePathway HMO and BlueJourney PPO Medicare Advantage plans. BCBSAZ Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Medicare Advantage Standard, Classic and Plus HMO plans.

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REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

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$0 monthly premium (H0302-008)

Santa Cruz County

☐ Blue Medicare Advantage Standard (HMO)
$0 monthly premium (H0302-009)

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.

Name:_____
(as it appears on your Medicare card)

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

Is Entitled To — Effective Date (MM/DD/YYYY)

HOSPITAL (Part A) _____/_____/_____

MEDICAL (Part B) _____/_____/_____

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

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ___ ___ / ___ ___ / ___ ___ ___ ___ (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Phone Number: ( )	
Permanent Residence Street Address (P.O. Box is not allowed):			Apt. #:
City:	State:		ZIP Code:
County:	Email Address¥:		
Mailing Address (only if different from your Permanent Residence Address):			Apt. #:
City:	State:		ZIP Code:
Alternate Contact:	Phone Number: ( )		Relationship to you:

Please choose the name of a Primary Care Provider (PCP):_____
(FIRST Name) *(LAST Name)*

Is this your current Primary Care Provider? ☐ Yes ☐ No

Please note: if you do not provide the name of a PCP, one will be assigned for you by the plan.

Have you recently moved into the service area for the plan you selected above? ☐ Yes ☐ No
If yes, Date of Move _____/_____/_____

¥By providing this email address, I agree to receive email communications from BCBSAZ Advantage (e.g., certain plan documents and health education materials).

*Our service area includes all of Maricopa, Pima, Santa Cruz, and Pinal counties.

Enrollee Name: _____

PLEASE READ AND ANSWER THESE 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 BCBSAZ Advantage Medicare Prescription Drug Coverage? ☐ Yes ☐ No

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

   Name of other coverage: _____

   ID # for this coverage: _____ Group # for this coverage: _____

   Plan Start Date for this coverage: ___ ___ / ___ ___ / ___ ___ ___ ___
   M M / D D / Y Y Y Y

   Plan End Date for this coverage: ___ ___ / ___ ___ / ___ ___ ___ ___
   M M / D D / Y Y Y Y

2. Are you enrolled in your State Medicaid (AHCCCS) program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: _____

3. 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: _____

   Phone Number of Institution: _____

   Address (number and street): _____

4. Please check one of the boxes below if you would prefer us to send you information in Spanish, large print or an alternate format: ☐ Spanish ☐ large print ☐ alternate format:_____

Please call Member Services at 480-937-0409 (in Arizona) or toll-free phone number 1-800-446-8331. We are available from 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30; and seven days a week from October 1 to March 31. TTY users should call 711.

Comuníquese con nuestro Departamento de Servicio al Cliente al 480-937-0409 (en Arizona) o al número gratuito 1-800-446-8331 para obtener información adicional. Los usuarios de TTY deben llamar al 711. El horario de atención es de 8:00 a.m. a 8:00 p.m., de lunes a viernes del 1 de abril al 30 de septiembre; y los 7 días de la semana del 1 de octubre al 31 de marzo.

Enrollee Name: _____

Typically, you may enroll in a Medicare Advantage plan only during the annual 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.

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

☐ 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 (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) _____.

Enrollee Name: _____

☐ 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) _____.

☐ 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 was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Blue Cross Blue Shield of Arizona Advantage at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1 – March 31, seven days a week, 8 a.m. to 8 p.m., April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m. Or, visit our website at www.azbluemedicare.com.

Do you currently have a Medicare Supplement plan? ☐ Yes ☐ No

☐ I understand I am signing up with a Medicare Advantage Plan with a Part D pharmacy plan. I understand I cannot combine a Medicare Supplement or Medigap plan with a Medicare Advantage plan.

Enrollee Name: _____

BlueCross BlueShield Arizona

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2022 Enrollment Receipt

Please use this as your temporary proof of coverage until Medicare has confirmed your enrollment, and you receive your member ID card. **This receipt is not a guarantee of enrollment.**

This copy is for your records only. Please do not resubmit enrollment.

Fill out this plan recap with your Licensed Sales Representative (if applicable). It will take you through some plan details to help you better understand your new plan.

Here are some details about your new plan:

Enrollee Name:		
Application Date:	My plan coverage begins (effective date):	
My new plan name is: ☐ Blue Medicare Advantage Standard (H0302-009) (Santa Cruz County) ☐ Blue Medicare Advantage Classic (H0302-008) (Pima County) ☐ Blue Medicare Advantage Classic (H0302-006) (Maricopa/ Pinal County) ☐ Blue Medicare Advantage Plus (H0302-001) (Maricopa/ Pinal County)	☐ BluePathway Plan 1 (H6936-006) (Maricopa County) ☐ BluePathway Plan 2 (H6936-003) (Maricopa County) ☐ BluePathway Plan 2 (H6936-005) (Pima County)	☐ BluePathway Plan 3 (H6936-004) (Maricopa County) ☐ BlueJourney (H5140-001) (Maricopa County) ☐ BlueJourney (H5140-002) (Pima County)
My plan type is: ☐ HMO ☐ LPPO	RxBIN: 015574 RxPCN: ASPROD1 RxGRP: BHP01	
Premium Information: My plan has a: $ _____ monthly premium. I understand I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me. If I owe a Late Enrollment Penalty (LEP), it is not included in my premium and I will need to add it to my premium each month.		
I must live in the plan's service area. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.		
I can cancel my enrollment in this plan before my coverage starts by calling Member Services at ***480-937-0409*** (in Arizona) or toll-free at ***1-800-446-8331 (TTY users should call 711). We are open October 1 – March 31, seven days a week, 8 a.m. to 8 p.m.; April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m.*** Once my coverage starts, I may have to wait until the Open Enrollment Period to make a plan change, unless I qualify for a Special Election Period.		
Call your Licensed Sales Representative if you have any questions:		
Licensed Sales Representative Name and ID Number	Licensed Sales Representative Phone No.	

Enrollee Name: _____

PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

You can pay your monthly plan premium and/or any late enrollment penalty that you currently have or may owe, by Electronic Funds Transfer, credit card or by mail. You can also choose to pay your premium and/or late enrollment penalty 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 (IRMAA), 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 BCBSAZ Advantage 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.

Please select premium/late enrollment penalty payment option below *(if you don't select a payment option, you will get a bill each month):*

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Bank name: _____ Account type: ☐ Checking ☐ Savings

Bank routing number: _____ Bank account number: _____

☐ Get a monthly bill (You can pay your monthly bill with a check or call us to pay with a credit card)

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

Enrollee Name: _____

STOP

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining BCBSAZ Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCBSAZ Advantage. 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 READ AND SIGN BELOW

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

1. BCBSAZ Advantage 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 (except for supplements) 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: October 15 – December 7 of every year**), or under certain special circumstances.
2. BCBSAZ Advantage serves a specific service area. If I move out of the area that BCBSAZ Advantage 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 BCBSAZ Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BCBSAZ Advantage 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.
3. I understand that beginning on the date BCBSAZ Advantage coverage begins, I must get all of my healthcare from BCBSAZ Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCBSAZ Advantage and other services contained in my BCBSAZ Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BCBSAZ Advantage WILL PAY FOR THE SERVICES**.
4. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BCBSAZ Advantage, he/she may be paid based on my enrollment in BCBSAZ Advantage.

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

Signature: **X**_____ Today's Date: _____

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

Name: _____ Address: _____

Phone Number: (____)_____ Relationship to Enrollee: _____

Office Use Only:

Member ID #: _____ Plan Effective Date: _____ ICEP/IEP: _____ AEP: _____ OEP: _____

SEP: ____ / SEP Reason: _____ Not Eligible: ____ Enrollment Rep: _____ Completed Date: _____

For Use by Agent/Broker:

Certified Agent Name (Print): _____ Agent/Broker #:_____

Broker of Record*: _____ Requested Effective Date: _____

Agent/Broker Signature: _____

Date Received:_____ Phone Number: _____

**Enter the Name of the Entity contracted with BCBSAZ Advantage*

An Independent Licensee of the Blue Cross Blue Shield Association