PREMERA BLUE CROSS MEDICARE ADVANTAGE PLANS

Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or 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 Advantage Plan, you must also have 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 January1)
- Within 3 months of first getting Medicare
- 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.

PREMERA BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

What happens next?

Send your completed and signed form to:
Premera Blue Cross
PO Box 262548
Plano, TX 75026

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

How do I get help with this form?

Call Premera Blue Cross Medicare Advantage at 888-868-7767 (TTY/TDD:711). Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Premera Blue Cross Medicare Advantage al 888-868-7767 (TTY/TDD:711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

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 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.

Section 1 – All fields on this page are required

(unless marked optional)

SELECT THE PLAN YOU WANT:

KING • PIERCE • SNOHOMISH • THURSTON

- ☐ **HMO - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Classic HMO - $55**
- ☐ **Classic Plus HMO - $191**
- ☐ **Peak + Rx (HMO) - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Sound + Rx (HMO) - $40**
- ☐ **Charter + Rx (HMO) - $151**
- ☐ **Alpine (HMO) - $42** (no prescription coverage)

LEWIS • KITSAP • COWLITZ

- ☐ **HMO - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Classic HMO - $55**

SPOKANE

- ☐ **HMO - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Total Health HMO - $24**

STEVENS

- ☐ **Total Health HMO - $24**

SKAGIT • ISLAND • SAN JUAN • WALLA WALLA

- ☐ **Core HMO - $12**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Core Plus HMO - $75**

WHATCOM

- ☐ **Core HMO - $12**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Peak + Rx (HMO) - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Sound + Rx (HMO) - $40**
- ☐ **Charter + Rx (HMO) - $151**
- ☐ **Alpine (HMO) - $42** (no prescription coverage)
- ☐ **Classic (HMO) - $55**

YOUR INFORMATION

First Name: Last Name: Mid Int: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: Sex: ☐ M ☐ F Phone:

Email Address: Send materials electronically: ☐ Yes ☐ No

Permanent residence (PO box is not allowed)

Street Address: City:

Optional: County: State: Zip:

Mailing address (only if different from permanent residence address)

Street Address: City:

County: State: Zip:

Emergency contact

Name: Phone:

Relationship to You:

Choose the name of a Primary Care Provider (PCP):

PCP Location:

PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare card to complete this section.

- Please fill in the blanks so they match your red, white, and blue Medicare card.

––– OR –––

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

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

Name (as it appears on your Medicare card):

Medicare #:

Is entitled to	EFFECTIVE DATE
HOSPITAL (Part A)	
MEDICAL (Part B)	

OFFICE USE ONLY

OFFICE USE ONLY:

AGENT NAME:		WRITING #:	
SCOPE OF APPOINTMENT: ☐ PAPER ☐ APP MAILED TO AGENT ☐ SEMINAR (DATE / LOCATION):		AGENT RECEIVED DATE: EFFECTIVE DATE: SEP TYPE:	
PBP:	PLAN #:	CONTRACT #:	GROUP #:

OFFICE USE ONLY

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 coverage in addition to Premera Blue Cross? ☐ 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: _____

Section 2 - All fields on this page 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. ☐ Spanish

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

Please contact Premera Medicare Advantage at 888-868-7767 (TTY/TDD:711) if you need information in an accessible format other than what's listed above. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., October 1–March 31).

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

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Premera Blue Cross.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Premera 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.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Premera Blue Cross Medicare Advantage (HMO), or Premera Blue Cross Medicare Advantage Classic (HMO), or Premera Blue Cross Medicare Advantage Classic Plus (HMO), or Premera Blue Cross Medicare Advantage Total Health (HMO), or Premera Blue Cross Medicare Advantage Core (HMO), or Premera Blue Cross Medicare Advantage Peak + Rx (HMO), or Premera Blue Cross Medicare Advantage Sound + Rx (HMO), or Premera Blue Cross Medicare Advantage Charter + Rx (HMO), or Premera Blue Cross Medicare Advantage Alpine (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Premera Blue Cross. Benefits and services provided by Premera Blue Cross and contained in my Premera Blue Cross "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Premera Blue Cross will pay for benefits or services that are not covered.
- 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: _____ Date: __ __ / __ __ / __ __ __ __

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

Name: _____ Address: _____ Phone number: _____

Relationship to Enrollee: _____

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 Electronic Funds Transfer (EFT) 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 Premera Blue Cross the Part D-IRMAA.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month. Enclose a VOIDED check or provide the following:

Account Holder Name:	Account type: ☐ Checking ☐ Savings
Bank Routing #:	Bank Account #:

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**
(Please note: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. Before the deduction begins, you may receive invoices for your premium. You will be responsible for paying your monthly premium directly to Premera from your effective date until the date your withholding begins. Invoices will stop once the deduction is approved. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

I get monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 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.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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 applied 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 enrolling during the Annual Enrollment Period from October 15 through December 7.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.
- ☐ 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 _____.
- ☐ I recently returned from incarceration. I was released on _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____.
- ☐ I recently obtained lawful presence status in the United States. I got status on _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____.
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ 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 _____.
- ☐ 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 _____.
- ☐ I recently left a PACE program _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's coverage). I lost my drug coverage on _____.
- ☐ I am leaving employer or union coverage on _____.
- ☐ 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 _____.
- ☐ 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 _____.
- ☐ I was impacted by a significant network change with my current plan and was notified on: _____.
- ☐ 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 a natural disaster.

If none of these statements applies to you or you're not sure, please contact Premera Blue Cross at 888-868-7767 (TTY/TDD: 711) to see if you are eligible to enroll. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., from October 1–March 31).

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, Premera Blue Cross Medicare Advantage Plans - Complaints & Appeals, PO Box 262527, Plano, TX 75026, Phone: 888-850-8526, Fax: 800-889-1076, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-850-8526 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-850-8526（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-850-8526 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-850-8526 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-850-8526 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-850-8526 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 888-850-8526 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 888-850-8526 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-850-8526（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፣ ወደ ሚከተለው ቁጥር ይደውሉ 888-850-8526 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 888-850-8526 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-850-8526 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-850-8526 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-850-8526 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 888-850-8526 (TTY: 711).

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on renewal.