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.

**To join a plan, you must meet the following requirements:**

- Be a U.S. citizen or be lawfully present in the United States
- 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 during the following times:

- Between October 15 and December 7 each year (for coverage starting January 1)
- 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 the Annual Enrollment Period (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.

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**What happens next?**

Send your completed and signed form to:
Premera Blue Cross
PO Box 211151
Eagan, MN 55121

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

**How do I get help with this form?**

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

Llame a Premera Blue Cross Medicare Advantage al 888-868-7767 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español 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.

**Individuals experiencing homelessness**

If you want to join a plan but have no permanent residence, one of the following may be considered your permanent residence:

- A post office box
- An address of a shelter or clinic
- An address where you receive other mail (such as social security checks)

**Important: Do not send this form or any items with your personal information (such as claims, payments, medical records, and more) 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.**

To file a complaint about your Medicare health or drug plan, call 1-888-868-7767 (TTY: 711), or complete the Medicare Complaint form at **medicare.gov/my/medicare-complaint**. Call 1-800-MEDICARE (1-800-633-4227).
TTY users can call 1-877-486-2048. 1-800-MEDICARE is available 24 hours a day, 7 days a week, except some federal holidays. If applicable, please provide your agent or broker's name used for enrollment.

# Section 1 – All fields on this page are required

(unless marked optional)

All plans include preventive and comprehensive dental.

SELECT THE PLAN YOU WANT:

**COWLITZ • ISLAND • KING • KITSAP • LEWIS • PIERCE • SAN JUAN • SKAGIT • SNOHOMISH • THURSTON • WHATCOM**

- ☐ **HMO - $0**
- ☐ **Classic (HMO) - $54**

**SPOKANE • WALLA WALLA**

- ☐ **HMO - $0**
- ☐ **Classic (HMO) - $54** (not available in Spokane)
- ☐ **Total Health (HMO) - $23**

**STEVENS**

- ☐ **Total Health (HMO) - $23**

## YOUR INFORMATION

First name: Last name: Mid initial:

Birth date: Sex: ☐ M ☐ F Phone:

Email address: Cell phone:

**Permanent residence** (PO Box is not allowed)

Street address: City:

County (optional): State: ZIP code:

**Mailing address**, only if different from permanent residence address (PO Box allowed)

Street address: City:

State: Zip:

**Emergency contact**

Name: Phone:

Relationship to you:

**Name of primary care provider (PCP)**:

PCP location:

## PROVIDE YOUR MEDICARE INSURANCE INFORMATION

**Please use your Medicare card to complete this section.**

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

**OR**

- Attach a copy of your Medicare card, 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) | |

**AGENT USE ONLY**

**REQUIRED FOR AGENT SUBMITTED APPLICATION**

| | |
|---|---|
| AGENT NAME: | WRITING #: |
| Initial method of contact:<br>Lead Source: | |
| ENROLLMENT TYPE:<br>☐ IN PERSON ☐ VIA EMAIL<br>☐ TELEPHONIC ☐ MAILED TO AGENT | AGENT RECEIVED DATE:<br>EFFECTIVE DATE:<br>SEP TYPE: |

**AGENT 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," 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: _____

**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 I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan, unless it is an MA PFFS or an MA MSA 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 Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Premera Medicare Advantage. Benefits and services provided by Premera Medicare Advantage and contained in my Premera Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Premera Medicare Advantage 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.

  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: _____ Phone: _____

Address: _____

Relationship to enrollee: _____

# 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 a check box if you want us to send you information in a language other than English. ☐ Spanish

Select a check box if you want us to send you information in an accessible format. ☐ Braille ☐ Large print
☐ Other: _____

Contact Premera Medicare Advantage at 888-868-7767 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. – 8 p.m., seven days a week from October 1 through March 31; or 8 a.m. – 8 p.m., Monday through Friday from April 1 to September 30.

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

## RACE AND ETHNICITY

### RACE

- ☐ **Asian Indian**
- ☐ **Chinese**
- ☐ **Filipino**
- ☐ **Guamanian or Chamorro**
- ☐ **Japanese**
- ☐ **Korean**
- ☐ **Native Hawaiian**
- ☐ **Other Asian origin**
- ☐ **Other Pacific Islander origin**
- ☐ **Samoan**
- ☐ **Vietnamese**
- ☐ **America Indian or Alaska Native**
- ☐ **Black or African American**
- ☐ **White**
- ☐ **I choose not to answer**

### ETHNICITY

- ☐ **Not of Hispanic or LatinX, or Spanish origin**
- ☐ **Puerto Rican**
- ☐ **Another Hispanic or LatinX, or Spanish origin**
- ☐ **Mexican, Mexican American, Chicano/a**
- ☐ **Cuban**
- ☐ **I choose not to answer**

**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.

**You will automatically receive a monthly bill for your plan premium, if any, including any late enrollment penalty that you may have incurred. Or you can choose a different payment option listed below:**

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

| Account holder name: | Account: ☐ 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), to improve care, and for the payment of Medicare benefits. Sections 1851 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.

**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 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 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, or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ 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, plan to move in, or plan to move out of the facility on _____.
- ☐ I recently left a PACE program on _____.
- ☐ 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 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.

**If none of these statements applies to you or you're not sure, please contact Premera Blue Cross at 888-868-7767 (TTY: 711) to see if you are eligible to enroll. Our office hours are 8 a.m.—8 p.m., seven days a week from October 1 through March 31; or 8 a.m.—8 p.m., Monday through Friday from April 1 to September 30.**

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# Notice of Nondiscrimination

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, sex, gender identity, or sexual orientation. 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
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - 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, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Coordinator — Complaints and Appeals
Premera Blue Cross Medicare Advantage Plans
PO Box 21481, Eagan, MN 55121
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.

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

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Form Approved
OMB# 0938-1421

# Multi-Language Insert

## Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-850-8526 (TTY/TDD: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-850-8526 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-850-8526 (TTY/TDD: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-850-8526 (TTY/TDD: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-850-8526 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-850-8526 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-850-8526 (TTY/TDD: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-850-8526 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-850-8526 (TTY/TDD: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-850-8526 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-850-8526 (TTY/TDD: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-850-8526 (TTY/TDD: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-850-8526 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-850-8526 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-850-8526 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-850-8526 (TTY/TDD: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-850-8526 (TTY/TDD: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。