

Blue Shield Medicare Rx Plan and Blue Shield Medicare Rx Enhanced Plan Enrollment Form

To enroll in one of the Blue Shield Medicare Rx Plans, please provide the following information

Please check which plan you want to enroll in:

_____ Blue Shield Medicare Rx Plan for \$37.70 per month

_____ Blue Shield Medicare Rx Enhanced Plan for \$42.30 per month

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	First name	Middle initial
Birth date (____/____/____) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (providing this information is optional)	
Home phone number ()		E-mail address	
Permanent residence street address			
Street		City	State ZIP code
Mailing address (only if different from your permanent residence address)			
Street		City	State ZIP code

Please provide your Medicare insurance information

Please refer to 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 Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: _____

Medicare Claim Number:

Is Entitled To	Effective Dates
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Paying your plan premium

You can pay your Medicare drug plan directly for your monthly plan premium, or have the monthly plan premium automatically deducted from your Social Security check. If you choose to pay directly, you can pay by mail or by Electronic Funds Transfer (EFT) monthly.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.

Please select a plan premium payment option:

_____ Receive a monthly statement and pay by mail.

_____ Electronic Funds Transfer (EFT) from your bank account each month. Please fill out the Blue Shield Medicare Rx Plan's Easy\$Pay form included in this package. If you do not have a copy of the form, please call us and we will send you one.

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

Please answer the following 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 the Blue Shield Medicare Rx Plan or Blue Shield Medicare Rx Enhanced Plan?

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 Yes, please provide the following information:

Name of institution _____

Address and phone number of institution (number and street) _____



Please read this important information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining one of the Blue Shield Medicare Rx Plans, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining one of the Blue Shield Medicare Rx Plans could affect your employer or union health benefits. If you have health coverage from an employer or union, joining one of the Blue Shield Medicare Rx Plans may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on who 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: The Blue Shield Medicare Rx Plans are Medicare drug plans and are in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the Blue Shield Medicare Rx Plan or Blue Shield Medicare Rx Enhanced Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in Blue Shield Medicare Rx Plan or Blue Shield Medicare Rx Enhanced Plan will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to the plan or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days per week. TTY users should call 1-877-486-2048.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

The Blue Shield Medicare Rx Plans serve a specific service area. If I move out of the area, 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 the Blue Shield Medicare Rx Plan or Blue Shield Medicare Rx Enhanced Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from the Blue Shield Medicare Rx Plan or Blue Shield Medicare Rx Enhanced Plan when I receive it to know which rules I must follow to receive coverage with this Medicare drug plan.

Release of information: By joining this Medicare prescription drug plan, I acknowledge that the plan will release my information to Medicare or other plans as necessary for treatment, payment, and healthcare operations. I also acknowledge that the plan 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 behalf of the individual under the laws of the state where the individual resides) 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 Blue Shield of California or by Medicare.

Your signature

Today's date

If you are the authorized representative, (i.e., power of attorney, or legal guardian – see description above), you must provide the following information:

Name _____

Address _____

Phone number (_____) _____ – _____ Relationship to enrollee _____

Producer information (for producer use only):

Producer name _____ Producer ID No. _____

Producer phone number (_____) _____ – _____ Producer signature _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Marketing Guidelines and Enrollment rules and agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with rules.

Medicare Prescription Drug Plan use only:

Plan ID No. _____

Effective date of coverage _____ IEP _____ AEP _____ SEP (type) _____

Plan representative signature _____