



Attn: Medicare Enrollment Processing  
PO Box 211316, Eagan, MN 55121  
Phone: 1-877- 883-9577  
TTY: 1-800- 662-1220  
Monday – Friday, 8 a.m. – 8 p.m.  
From October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week

## 2020 Optional Supplemental Dental Plan Application

### Name of the Plan You are Enrolling In:

**Complementary Dental Plan \$29/month**

For those currently enrolled in:

- Medicare Blue Choice® Advanced (HMO-POS)
- Medicare Blue Choice® Optimum (HMO-POS)
- Medicare Blue Choice® Value (HMO)
- Medicare Blue Choice® Value Plus (HMO-POS)

**Full Comprehensive Dental Plan \$39/month**

For those currently enrolled in:

- Medicare Blue Choice® Platinum (HMO-POS)
- Medicare Blue Choice® Select (HMO)

**NAME:**

**MEMBER NUMBER:**

**HOME PHONE NUMBER:**

**PERMANENT STREET ADDRESS (P.O.BOX IS NOT ALLOWED):**

**CITY:**

**COUNTY:**

**STATE:**

**ZIP CODE:**

**MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT STREET ADDRESS):**

**CITY:**

**STATE:**

**ZIP CODE:**

**PLEASE FILL OUT THE FOLLOWING:**

I am currently a member of the \_\_\_\_\_ plan in Excellus BlueCross BlueShield.

Let us know if you would prefer us to send you information in a language other than English or in an accessible format.

Please call us at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday through Friday, 8 a.m. to 8 p.m.; From October 1-March 31, representatives are available to assist you 7 days a week, from 8 a.m. to 8 p.m.

Excellus BlueCross BlueShield is an HMO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal. A nonprofit independent licensee of the Blue Cross Blue Shield Association.

## Your Plan Premium

**The method you currently use to pay for your Medicare Advantage plan will be the same way you pay for your dental plan.**

Ways to pay your monthly plan premium are by mail, electronic funds transfer (EFT) or by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you'd like to change the method you're currently using to pay for your plans, please call Customer Care at 1-877-883-9577 (TTY: 1-800-662-1220), Monday - Friday, 8:00 a.m. to 8:00 p.m.; From October 1 to March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.



### Please Read This Important Information



### Please Read and Sign Below

Excellus BlueCross BlueShield is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Excellus BlueCross BlueShield, he/she may be paid based on my enrollment in Excellus BlueCross BlueShield.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Excellus BlueCross BlueShield will release my information 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Excellus BlueCross BlueShield coverage begins, I must get all of my health care from Excellus BlueCross BlueShield, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Excellus BlueCross BlueShield and other services contained in my Excellus BlueCross BlueShield Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR EXCELLUS BLUECROSS BLUESHIELD WILL PAY FOR THE SERVICES.**

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:**

**Today's Date:**

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

**NAME:**

**RELATIONSHIP TO ENROLLEE:**

**ADDRESS:**

**PHONE NUMBER:**

<b>Office Use Only:</b>		Plan ID#:
Effective Date of Coverage:		
Name of staff member/agent/broker (if assisted in enrollment):		
<b>Agent/Broker Signature:</b>	<b>NPN: #</b>	<b>Date Received:</b>

## **Discrimination is Against the Law**

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Our Health Plan:

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 our dedicated Medicare Customer Care representatives at 1-877-883-9577, (TTY: 1-800-662-1220). Monday - Friday, 8 a.m. - 8 p.m.  
From October 1 - March 31, 8 a.m. - 8 p.m., 7 days a week.

If you believe that our Health Plan 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:

Advocacy Department  
Attn: Civil Rights Coordinator  
PO Box 4717  
Syracuse, NY 13221  
Telephone Number: 1-800-614-6575 (TTY: 1-800-662-1220)  
Fax Number: 315-671-6656

You can file a grievance in person, or by mail or fax. If you need help filing a grievance, our Health Plan's 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 Avenue, 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>.

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A nonprofit independent licensee of the Blue Cross Blue Shield Association

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-877-883-9577 (TTY: 1-800-662-1220).

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-883-9577 (TTY: 1-800-662-1220).

**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 1-877-883-9577 (TTY: 1-800-662-1220)。

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-883-9577 (телетайп: 1-800-662-1220).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-883-9577 (TTY: 1-800-662-1220).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-883-9577 (TTY: 1-800-662-1220)번으로 전화해 주십시오.

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-883-9577 (TTY: 1-800-662-1220)

**লক্ষ্য করুন:** যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৭৭-৮৮৩-৯৫৭৭ (TTY: ১-৮০০-৬৬২-১২২০)।

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-883-9577 (TTY: 1-800-662-1220).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-883-9577 (رقم هاتف الصم والبكم: 1-800-662-1220).

**ATTENTION :** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-883-9577 (ATS : 1-800-662-1220).

**خبردار:** اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877-883-9577 (TTY: 1-800-662-1220).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220).

**ΠΡΟΣΟΧΗ:** Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-883-9577 (TTY: 1-800-662-1220).

**KUJDES:** Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-883-9577 (TTY: 1-800-662-1220).

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