2027 Excellus BlueCross BlueShield Medicare HMO Individual Enrollment Request Form

Excellus BlueCross BlueShield is a HMO plan with a Medicare contract.
Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

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A nonprofit independent licensee of the Blue Cross Blue Shield Association

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

WHO CAN USE THIS FORM?

- People with Medicare who want to join a Medicare Advantage 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 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 and Section 3. 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.

WHAT HAPPENS NEXT?

Send your completed and signed form to:

Excellus BlueCross BlueShield

Attn: Enrollment Operations

PO Box 31790

Rochester, NY 14603-1790

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

HOW DO I GET HELP WITH THIS FORM?

Call Excellus BlueCross BlueShield at 1-800-659-1986. TTY users can call 1-800-662-1220.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Excellus BlueCross BlueShield al 1-800-659-1986/TTY 1-800-662-1220 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

INDIVIDUALS EXPERIENCING HOMELESSNESS

- If you want to join a plan, but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Section 1 - All fields on this page are required (unless marked optional)

For Internal Use

Select the plan you want to join:

- ☐ Medicare Blue Choice® 024 (HMO) $0 per month
- ☐ Medicare Blue Choice® 027 (HMO-POS) $0 per month
- ☐ Medicare Blue Choice® 025 (HMO-POS) $75.30 per month
- ☐ Medicare Blue Choice® 026 (HMO-POS) $115.30 per month

☐ Optional Full Comprehensive Dental $35 per month

FIRST NAME: **LAST NAME:** **MIDDLE INITIAL:**

BIRTH DATE (MM/DD/YYYY): **SEX:** ⑤ MALE ⑤ FEMALE **PHONE NUMBER:** ( )

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY: **COUNTY:** **STATE:** **ZIP CODE:**

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

Your Medicare Information:

MEDICARE NUMBER:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Excellus BlueCross BlueShield ? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

IMPORTANT: Read and Sign on the Next Page:

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Excellus BlueCross BlueShield.
- By joining this Medicare Advantage Plan, I acknowledge that Excellus BlueCross BlueShield 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.
- 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 (exceptions apply for MA PFFS, MA MSA plans).
- If you currently have a Medicare Supplement policy in place, you will need to submit a written request to your carrier to disenroll from that coverage.
- I understand that when my Excellus BlueCross BlueShield coverage begins, I must get all of my medical and prescription drug benefits from Excellus BlueCross BlueShield. Benefits and services provided by Excellus BlueCross BlueShield and contained in my Excellus BlueCross BlueShield "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Excellus BlueCross BlueShield will pay for benefits or services that are not covered.
- 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 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:
    - This person is authorized under State law to complete this enrollment, and
    - Documentation of this authority is available upon request by Medicare.

SIGNATURE:

TODAY'S DATE:

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

NAME:

ADDRESS:

PHONE NUMBER:

( )

RELATIONSHIP TO ENROLLEE:

Section 2 - All fields in this section 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 an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

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

List your Primary Care Physician (PCP): _____

Please fill in your cell phone and/or email address.

Cell Phone Number: ( )

Email Address: _____

Electronic Communications

Please check the boxes for ALL forms of electronic communication you would like to receive:

☐ I would like to receive SMS notifications (text messages) from Excellus BlueCross BlueShield. Message and data rates may apply.

☐ I would like Email notifications from Excellus BlueCross BlueShield.

Section 3 - 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. DON'T pay Excellus BlueCross BlueShield the Part D-IRMAA.

If you will be receiving any form of premium assistance due to Low Income Subsidy or EPIC, you must continue to pay the amount on your monthly bill. Your bill will reflect the lower premium once the notification has been received and applied to your account.

If you don't select a payment option, you will get a bill each month.

Please select one premium payment option:

☐ **Get a bill each month.**

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

ACCOUNT HOLDER NAME:

BANK ROUTING NUMBER:

BANK ACCOUNT NUMBER:

ACCOUNT TYPE:

☐ CHECKING

☐ SAVINGS

☐ **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**. Any plan premiums due prior to the Social Security or RRB withhold start date will not be deducted from your check; therefore, you are still responsible for any outstanding premiums owed prior 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.)

***Please know that if you choose a payment option other than "Get a bill each month" you will be responsible to remit payment until you receive confirmation that your preferred payment method is in place.**

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, i mprove 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 i nformation. 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.

Send completed application to:
Excellus BlueCross BlueShield Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603-1790

Office Use Only:			Plan ID#:
Effective Date of Coverage:			
ICEP / IEP:	OEPI:	AEP / MA OEP:	SEP (type):
Name of staff member/agent/broker (if assisted in enrollment):			Not Eligible:
Agent/Broker Signature:		**NPN: #**	**Date Received:**

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 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 have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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) _____ .
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ 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 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 Excellus BlueCross BlueShield at 1-800-659-1986 (TTY users should call 1-800-662-1220) to see if you are eligible to enroll. We are open Monday - Friday, 8:00 a.m. - 8:00 p.m. From October 1 - March 31, 8:00 a.m. - 8:00 p.m., 7 days a week.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-883-9577 (TTY: 1-800-662-1220) or speak to your provider.

Spanish: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También se ofrecen de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-883-9577 (TTY: 1-800-662-1220) o hable con su proveedor.

Chinese-Traditional: 如果您說繁體中文，我們可免費提供語言援助服務。此外，我們亦可免費提供適當的輔助工具及服務，以協助您取得無障礙格式的資訊。請致電 1-877-883-9577（TTY：1-800-662-1220），或洽詢您的醫療服務提供者。

Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Кроме того, бесплатно предоставляются соответствующие вспомогательные услуги и сервисы для предоставления информации в доступных форматах. Позвоните по номеру 1-877-883-9577 (телетайп: 1-800-662-1220) или обратитесь к своему поставщику услуг.

Haitian Creole: Si w pale Kreyòl Ayisyen, gen sèvis asistans lengwistik ki disponib gratis pou ou. Gen aparèy ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòma ki aksesib ki disponib gratis tou. Rele nan 1-877-883-9577 (TTY: 1-800-662-1220) oswa pale ak pwofesyonèl swen sante w la.

Korean: 한국어를 구사하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 이용 가능합니다. 1-877-883-9577(TTY: 1-800-662-1220)로 전화하거나 서비스 제공업체에 문의하십시오.

Italian: Se parla italiano, potrà usufruire di servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente adeguati servizi sussidiari e di assistenza per fornire informazioni in formati accessibili. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220) o consultare il proprio fornitore.

Yiddish: אויב איר רעדט יידיש, זענען פרייע שפראך הילף סערוויסעס פאראנען פאר אייך. פאסיקע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמציע אין צוטריטלעכע פארמאַטן זענען אויך פאראנען פריי פון אפּצאל. איינרוף 1-877-883-9577 (TTY: 1-800-662-1220) אדער רעדט מיט אייער פראווייידער.

Bengali: আপনি যদি বাংলা বলতে পারেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য রয়েছে। তথ্য সহজলভ্য বিন্যাসে প্রদানের জন্য উপযুক্ত সহায়ক সরঞ্জাম এবং পরিষেবা বিনামূল্যে পাওয়া যায়। 1-877-883-9577 (TTY: 1-800-662-1220) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

Polish: Jeśli mówi Pan/Pani po polsku, może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. W celu dostarczenia informacji w przystępnym formacie dostępne są również bezpłatne dodatkowe pomoce i usługi. Prosimy zadzwonić pod numer 1-877-883-9577 (TTY: 1-800-662-1220) lub porozmawiać ze swoim świadczeniodawcą.

Arabic: إن كنت تتحدث العربية، تتوفر لك خدمات مساعدة لغوية مجانية .كما تتوفر المساعدات والخدمات الإضافية الملائمة لتقديم المعلومات بصيغ يسهل الوصول إليها مجانًا. اتصل بهذا الرقم 1-877-883-9577) رقم الهاتف النصي لضعاف السمع-TTY: 1-800-662-1220)أو تحدث إلى مُقدم الرعاية الخاص بك.

French: Si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Des aides et des services auxiliaires adaptés pour vous fournir des informations dans des formats accessibles vous sont également proposés gratuitement. Appelez le 1-877-883-9577 (TTY : 1-800-662-1220) ou parlez-en à votre prestataire.

Urdu: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں معاونت کی خدمات دستیاب ہیں۔ معلومات کو قابل رسائی انداز میں فراہم کرنے کے لیے مناسب معاون آلات اور خدمات بھی مفت فراہم کی جاتی ہیں۔ 1-877-883-9577پر کال کریں (TTY: 1-800-662-1220) یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo ng tulong sa wika. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220) o makipag-usap sa iyong provider.

Greek: Εάν μιλάτε Ελληνικά, είναι διαθέσιμες για εσάς δωρεάν υπηρεσίες γλωσσικής βοήθειας. Επίσης, διατίθενται χωρίς χρέωση κατάλληλα βοηθητικά μέσα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε στο 1-877-883-9577 (TTY: 1-800-662-1220) ή μιλήστε με τον πάροχό σας.

Albanian: Nëse flisni shqip, ofrohen falas për ju shërbime të asistencës gjuhësore. Gjithashtu ofrohen falas mjete dhe shërbime ndihmëse të përshtatshme për të ofruar informacionin në formate të aksesueshme. Telefononi 1-877-883-9577 (TTY: 1-800-662-1220) ose flisni me ofruesin tuaj.

Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires that a Sales Agent use this form to document the scope of a marketing appointment before the face-to-face sales meeting to ensure your appointment is for the type of plan(s) you're interested in. A separate form should be completed for each person at the meeting. These scopes are required for telephonic and virtual visits too. All information is confidential. **Please initial the box(es) below beside the plan(s) you want the agent to discuss with you.**

☐ Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only go to doctors or hospitals in the plan's network (except in emergencies or specific urgent care situations).

Medicare Preferred Provider Organization (PPO) Plan — Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost* (except in emergencies or specific urgent care situations).

Medicare Dual Eligible Special Needs Plan (D-SNP) — A Medicare Advantage Plan for people who have both Medicare and New York State Medicaid. The plan provides all Original Medicare Part A and Part B health coverage, Part D prescription drug coverage and some Medicaid coverage. You can only go to doctors or hospitals in the plan's network (except in emergencies or specific urgent care situations).

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) -- A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost plans, some Medicare Private Fee-for-Service plans, and Medicare Medical Savings Account plans.

By signing this form, you agree to meet with a Sales Agent to discuss the products checked above. The Sales Agent is either employed or contracted by a Medicare plan and may be compensated based on your enrollment in a plan. This individual does not work directly for the Federal Government.

Signing this form does NOT affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: **Signature Date:**

If you are the authorized representative, please sign above and print below:

Representative's Name:

Your Relationship to the Beneficiary:

To be completed by Sales Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Plan(s) represented during this meeting:	
Agent, if the form was signed by the beneficiary at the time of appointment, provide an explanation why SOA was not documented prior to meeting:	
Agent's Signature:	Date appointment was completed:

*For PPO Plans: Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Customer Care number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Excellus BlueCross BlueShield • 333 Butternut Drive, Syracuse, NY 13214

ExcellusMedicare.com

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