2017 Excellus BlueCross BlueShield Medicare PPO and HMO Individual Enrollment Request Form

Excellus BlueCross BlueShield contracts with the Federal Government and is an HMO plan and PPO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.
How to complete the Medicare Advantage Enrollment Application for Excellus BlueCross BlueShield

ENROLL - It’s fast and easy!

This enrollment form provides all the information you need to complete the application process. If you require any assistance with your application, please contact us online or by phone.

You can complete your application easily online, 24/7! Simply visit ExcellusMedicare.com and click on the “I am Ready to Enroll” button. Our simple online enrollment process will guide you from start to finish.

Our Medicare representatives are here to help you every step of the way. To speak with one of our licensed sales advisors, call us toll-free at 1-800-659-1986 (TTY/TTD users call 1-800-421-1220), Monday - Friday from 8:00 a.m. - 8:00 p.m. If you’re calling between October 1 and February 14, representatives are available seven days a week from 8:00 a.m. - 8:00 p.m.

You may complete this paper enrollment form and mail it back in the pre-paid envelope provided. We’ll take care of the rest.

Thank you for your interest in our Medicare Advantage plan. Please read the information below and follow these helpful steps to complete your paper enrollment form:

**Step 1:** Select a plan (Page 1)

**Step 2:** Include your Medicare Part A & B information (Page 1)

**Step 3:** Check the box to indicate how you want to be billed (Page 2)

**Step 4:** Read and answer questions (Page 2 & 3)

**Step 5:** Make sure you or your authorized representative have signed and dated the paper enrollment form. (Page 4)

To ensure that your application is processed on time and to prevent any delays, please complete ALL of the steps above and return all pages.
To Enroll in Excellus BlueCross BlueShield, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ Medicare BlueEssential (PPO) $0 per month  ☐ Medicare Bassett (HMO-POS) $106 per month
☐ Medicare BlueClassic (PPO) $40 per month  ☐ Medicare BlueEnhanced (PPO) $120 per month
☐ Medicare BlueSecure (PPO) $90 per month  ☐ Medicare BlueBasic (PPO) $57 per month

LAST NAME: FIRST NAME: MIDDLE INITIAL:  MR.  MRS.  MS.

BIRTH DATE (MM/DD/YYYY):  SEX:  HOME PHONE NUMBER:

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

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

CITY:  COUNTY:  STATE:  ZIP CODE:

CITY:  STATE:  ZIP CODE:

E-MAIL ADDRESS:

EMERGENCY CONTACT:

RELATIONSHIP TO YOU:  PHONE NUMBER:

Please Provide Your Medicare Insurance Information

Please take out 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 Social Security or the Railroad Retirement Board.

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

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Please contact Excellus BlueCross BlueShield if you need information in another language or format (Braille).
For a Zero Premium Plan: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. For Plans with a Premium: 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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Excellus BlueCross BlueShield the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don’t even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover.

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

Please select a 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. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up 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 read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)?
   ☐ YES ☐ NO
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.
If you currently have health coverage from an employer or union, joining Excellus BlueCross BlueShield could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Excellus BlueCross BlueShield. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

Excellus BlueCross BlueShield is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 -
December 7 of every year), or under certain special circumstances.

Excellus BlueCross BlueShield serves a specific service area. If I move out of the area that Excellus BlueCross BlueShield serves, 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 Excellus BlueCross BlueShield, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Excellus BlueCross BlueShield when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

HMO Plan: 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.

PPO Plan: I understand that beginning on the date Excellus BlueCross BlueShield coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Excellus BlueCross BlueShield provides refunds for all covered benefits, even if I get services out of network. 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 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 Excellus BlueCross BlueShield 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 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 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: ______________________

(_______) _______ _______ _______
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.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Date Inserted</th>
</tr>
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<tbody>
<tr>
<td>I am new to Medicare.</td>
<td></td>
</tr>
<tr>
<td>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 (insert date)</td>
<td></td>
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<tr>
<td>I recently was released from incarceration. I was released on (insert date)</td>
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<tr>
<td>I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)</td>
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<tr>
<td>I recently obtained lawful presence status in the United States. I got this status on (insert date)</td>
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<tr>
<td>I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.</td>
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<tr>
<td>I get extra help paying for Medicare prescription drug coverage.</td>
<td></td>
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<tr>
<td>I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)</td>
<td></td>
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<tr>
<td>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)</td>
<td></td>
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<tr>
<td>I recently left a PACE program on (insert date)</td>
<td></td>
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<tr>
<td>I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (insert date)</td>
<td></td>
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<tr>
<td>I am leaving employer or union coverage on (insert date)</td>
<td></td>
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<tr>
<td>I belong to a pharmacy assistance program provided by my state.</td>
<td></td>
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<tr>
<td>My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
</tbody>
</table>

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 1-800-421-1220) to see if you are eligible to enroll. We are open Monday - Friday, 8:00 a.m. - 8:00 p.m. From October 1 - February 14, our office hours are 8:00 a.m. - 8:00 p.m., 7 days a week.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-883-9577 (TTY: 1-800-421-1220).


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：1-800-421-1220）。


lngx korun: ydi aapani bangla, katha bhalo parbon, tahale nikhhorachay bhasha sahayota pariyebo upobad akhbo. fone korun 1-877-883-9577 (TTY: 1-800-421-1220)


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B-5606
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: 1-800-421-1220). Monday - Friday, 8 a.m. - 8 p.m. From October 1 - February 14, 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: 1-800-421-1220)
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)
