Blue Cross® Blue Shield® of Arizona Advantage Enrollment Form

Completing the Application Process

Please complete the application using black ballpoint pen, and press firmly.

There are detailed instructions on the inside page of this Enrollment Form.

BlueCross BlueShield of Arizona Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Thank you for choosing Blue Cross Blue Shield of Arizona Advantage

Blue Cross® Blue Shield® of Arizona Advantage Individual Enrollment Request Form

To enroll in Blue Cross Blue Shield of Arizona Advantage, please provide the following information:
(Please mark an "X" in the box next to the plan you want to enroll in)

Maricopa County and Select Pinal County Zip Codes*

- ☐ Blue Medicare Advantage Classic (HMO) **$0** monthly premium
- ☐ Blue Medicare Advantage Plus (HMO) **$29** monthly premium
- ☐ Blue Medicare Advantage Premier (HMO) **$89** monthly premium

Pima County

- ☐ Blue Medicare Advantage Classic (HMO) **$0** monthly premium

LAST Name: Smith	FIRST Name: Jane	Middle Initial: L.	☐ Mr. ☒ Mrs. ☐ Ms.
Birth Date: 06/03/1933 (MM/DD/YYYY)	Sex: ☐ M ☒ F	Home Phone Number: (602) 000-0000	
Permanent Residence Street Address (P.O Box is not allowed): 1234 West Street			Apt. #: 203
City: Phoenix	State: Arizona		ZIP Code: 85000
Mailing Address (only if different from your Permanent Residence Address): P.O. Box 56789			Apt. #:
City: Phoenix	State: Arizona		ZIP Code: 85000
Alternate Contact: Robert Smith	Phone Number: (602) 000-0000		Relationship to you: Brother

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.

MEDICARE HEALTH INSURANCE — SAMPLE ONLY

Name: Jane L. Smith

Medicare Claim Number 000-00-00000

Sex: ☐ M ☒ F

Is Entitled To	Effective Date
HOSPITAL (Part A)	01/01/2000
MEDICAL (Part B)	01/01/2000

Please choose the name of a Primary Care Physician (PCP): _____
(FIRST Name) *(LAST Name)*

Is this your current Primary Care Physician? ☐ Yes ☐ No

Have you changed your permanent residence in the past 90 days? ☐ Yes ☐ No

If yes, Date of Move _____/_____/_____

STEPS:

A. Select the plan you wish to enroll in.

B. Provide all personal information.

C. Provide address where you live.

D. Provide address (if applicable) where you receive your mail.

E. The person to contact if we are unable to contact you.

F. Provide your Medicare Insurance Information as it appears on your red, white, and blue Medicare I.D. card.

G. Provide the name of your Primary Care Physician (PCP). Without this information, your PCP will be automatically assigned for you by the plan.

*Our service area includes all of Maricopa, Pima and portions of Pinal Counties.
Pinal County zip codes include: 85117, 85118, 85119, 85120, 85140, 85142, 85143, 85178, 85217, 85218, 85219, 85220, 85240, 85243

H0302_504_2015
CMS Approved 08/05/2015

DETAILED INSTRUCTIONS

Please read the instructions and statements carefully. If you have any questions, please call Blue Cross Blue Shield of Arizona Advantage at the telephone numbers below.

A. WHICH PLAN ARE YOU ENROLLING IN – Mark an "X" in the box next to the Blue Cross Blue Shield of Arizona Advantage Health Plan you wish to enroll in.

B. NAME – Please print your name exactly as it is written on your Medicare Health Insurance Card, even if there is an error. Errors need to be corrected with your local Social Security Administration Office. We will be notified of your corrected name by the Centers for Medicare and Medicaid Services (CMS).

C. PERMANENT RESIDENCE STREET ADDRESS – This address should be your current residence, where you presently live (PO Box Address is NOT allowed). You must live within the Blue Cross Blue Shield of Arizona Advantage's service area to join this plan.

D. MAILING ADDRESS *(if different from your Permanent Residence)* – This address should be different from your permanent residence. An address where you receive your mail. If this address is the same as your permanent address, you do not need to fill this part out.

E. ALTERNATIVE CONTACT – Provide the name of a friend or relative, who does not reside with you, for an alternative contact should we be unable to reach you.

F. MEDICARE CLAIM NUMBER – Please print your Medicare Claim Number exactly as it is written on your Medicare Health Insurance Card. You must be entitled to Medicare Part A and enrolled in Medicare Part B to enroll in any of the Blue Cross Blue Shield of Arizona Advantage Health Plans. Please complete the effective dates of your Part A and B coverage on the form.

G. PRIMARY CARE PHYSICIAN – Please print the First and Last Name of your Primary Care Physician (PCP). If you do not complete this information, your PCP will be automatically assigned for you by the plan.

IMPORTANT INFORMATION – Read each statement carefully. If there is anything you do not understand, please contact Blue Cross Blue Shield of Arizona Advantage at the phone number below, during the hours of operations listed below.

SIGNATURE – By signing your enrollment form, you agree to follow the plan rules and have an understanding of your member responsibilities. If you have any questions, please call us. **Sign your name as it is listed on your Medicare Health Insurance Card, and date the form.** Keep the yellow copy of the enrollment form for your records. In most cases, we will acknowledge the receipt of your application in writing before the effective date. If someone is assisting you in completing this form, please contact Blue Cross Blue Shield of Arizona Advantage at the telephone numbers listed below for further instructions. If you have a representative that is completing this form on your behalf, your representative must be a Durable General Power of Attorney (DPOA) or court-ordered Legal Guardian to sign this form. Please provide a copy of the paperwork that shows that your representative is your DPOA or Legal Guardian. Lack of proof will not delay the processing of the application.

Mail the Individual Enrollment form to:
Blue Cross Blue Shield of Arizona Advantage
13950 W. Meeker Blvd., Sun City West, AZ 85375

Contact us at:
1-888-274-0367/TTY 711
We are available October 1 – February 14, 7 days a week, 8 a.m. to 8 p.m.
(February 15 – September 30, Monday–Friday, 8 a.m. to 8 p.m.)
Or, visit our website at www.AZBlueMedicare.com

Blue Cross Blue Shield of Arizona Advantage is an HMO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Arizona Advantage depends on contract renewal.

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Pima County

- ☐ Blue Medicare Advantage Classic (HMO) **$0** monthly premium

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	
Permanent Residence Street Address (P.O Box is not allowed):			Apt. #:
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			Apt. #:
City:	State:		ZIP Code:
Alternate Contact:	Phone Number: ( )		Relationship to you:

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

SAMPLE ONLY

- 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.

Name:_____

Medicare Claim Number__ __ __ - __ __ - __ __ __ __ __

Sex: ☐ M ☐ F

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

Please choose the name of a Primary Care Physician (PCP): _____
(FIRST Name) *(LAST Name)*

Is this your current Primary Care Physician? ☐ Yes ☐ No

Have you changed your permanent residence in the past 90 days? ☐ Yes ☐ No

If yes, Date of Move _____/_____/_____

*Our service area includes all of Maricopa, Pima and portions of Pinal Counties. Pinal County zip codes include: 85117, 85118, 85119, 85120, 85140, 85142, 85143, 85178, 85217, 85218, 85219, 85220, 85240, 85243

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.

2. 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 Blue Cross Blue Shield of Arizona Advantage? ☐ Yes ☐ No

   If "yes", please 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: _____

   Plan Start Date for this coverage: ___ ___ / ___ ___ / ___ ___ ___ ___
   M M / D D / Y Y Y Y

   Plan End Date for this coverage: ___ ___ / ___ ___ / ___ ___ ___ ___
   M M / D D / Y Y Y Y

3. Are you enrolled in your State Medicaid (AHCCCS) program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: _____

4. 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: _____

   Phone Number of Institution: _____

   Address (number and street): _____

5. Please check one of the boxes below if you would prefer us to send you information in Spanish or large print: ☐ Spanish ☐ large print

Please call Member Services at our toll-free phone number 1-800-446-8331 if you need information in another format or language than what is listed above. We are available from 8:00 a.m. to 8:00 p.m., Monday - Friday from February 15 to September 30; and 7 days a week from October 1 to February 14. TTY users should call 711.

Por favor, llame a nuestro departamento de servicio al cliente al número de teléfono gratuito 1-800-446-8331 si necesita información en otro formato o idioma que no está en la lista anterior. Estamos disponibles de 8:00 a.m. a 8:00 p.m., lunes a viernes desde el 15 de febrero hasta el 30 de septiembre; y los 7 días de la semana desde el 1 de octubre hasta el 14 de febrero. Los usuarios de TTY deben llamar al 711.

PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

You can pay your monthly plan premium and/or any late enrollment penalty that you currently have or may owe, by Electronic Funds Transfer, credit card or by mail. You can also choose to pay your premium and/or late enrollment penalty 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 RRB. **DO NOT pay Blue Cross Blue Shield of Arizona Advantage 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.

Please select premium/late enrollment penalty payment option below *(if you don't select a payment option, you will 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: _____ Account type: ☐ Checking ☐ Savings

Bank routing number: _____ Bank account number: _____

☐ Get a monthly bill (You can pay your monthly bill with a check or call us to pay with a credit card)

☐ 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 THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Blue Cross Blue Shield of Arizona Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross Blue Shield of Arizona Advantage. 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.

PLEASE READ AND SIGN BELOW

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

1. Blue Cross Blue Shield of Arizona Advantage 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 (except for supplements) 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. 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.
2. Blue Cross Blue Shield of Arizona Advantage serves a specific service area. If I move out of the area that Blue Cross Blue Shield of Arizona Advantage 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 Blue Cross Blue Shield of Arizona Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross Blue Shield of Arizona Advantage 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.
3. I understand that beginning on the date Blue Cross Blue Shield of Arizona Advantage coverage begins, I must get all of my healthcare from Blue Cross Blue Shield of Arizona Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Cross Blue Shield of Arizona Advantage and other services contained in my Blue Cross Blue Shield of Arizona Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE CROSS BLUE SHIELD OF ARIZONA ADVANTAGE WILL PAY FOR THE SERVICES**.
4. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Cross Blue Shield of Arizona Advantage, he/she may be paid based on my enrollment in Blue Cross Blue Shield of Arizona Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that Blue Cross Blue Shield of Arizona Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Blue Cross Blue Shield of Arizona Advantage 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: **X**_____ Today's Date _____

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

Name: _____ Address: _____

Phone Number: (____)_____ Relationship to Enrollee: _____

Office Use Only:

Member ID #: _____ Plan Effective Date: _____ ICEP/IEP: _____ AEP: _____

SEP: ____ / SEP Reason: _____ Not Eligible: ____ Enrollment Rep: _____ Completed Date: _____

For Use by Agent/Broker:

Certified Agent Name (Print): _____ Agent/Broker #:_____

Broker of Record*: _____ Requested Effective Date: _____

Agent/Broker Signature: _____ ICEP/IEP: ____ AEP: ____

SEP: ____ / SEP Reason: _____ Date Received:_____ Phone Number: _____

**Enter the Name of the Entity contracted with BCBSAZ Advantage*

Advantage

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