Florida Blue

P.O. Box 45296
Jacksonville, FL 32232-5296

Please contact BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS if you need information in another language or format (Braille).

BlueMedicare℠ Preferred (HMO)
BlueMedicare℠ Preferred HMO (HMO SNP)
BlueMedicare℠ Preferred POS (HMO POS)

A Medicare Advantage Health Care Plan
Individual Enrollment Form

To Enroll in BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS, please provide the following information:

Please check which plan you want to enroll in:

❍ BlueMedicare Preferred (HMO) (Clay, Duval, Manatee, Pinellas, Sarasota) $0 per month
❍ BlueMedicare Preferred POS (HMO POS) (Manatee, Pinellas, Sarasota) $0 per month
❍ BlueMedicare Preferred HMO (HMO SNP) (Clay, Duval, Manatee, Sarasota) $0 per month

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: ( )	Alternate Phone Number: ( )
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address:	City:	State:	ZIP Code:
E-mail Address:			

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): ____________________

Medicare Number: ____________________

Is Entitled To	Effective Date
HOSPITAL (PART A)	__________
MEDICAL (PART B)	__________

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

Paying Your Plan Premium:

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. 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 BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS 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.

Y0011_34032 0717 AP CMS Accepted

Please select a premium payment option:

❍ Get a bill monthly.

❍ **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 ❍ Saving

❍ 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. 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.
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 BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS? ❍ 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:

   _____ _____ _____
3. 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 & Phone Number of Institution (number and street):_____
   _____
4. Are you enrolled in your State Medicaid program? ❍ Yes ❍ No
   If "yes," please provide your Medicaid number: _____
5. Do you or your spouse work? ❍ Yes ❍ No
6. If you are enrolling in BlueMedicare Preferred HMO (HMO SNP), do you have:
   Diabetes ❍ Yes ❍ No Cardiovascular Disorders ❍ Yes ❍ No Chronic Heart Failure ❍ Yes ❍ No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ☐ Spanish ☐ Braille, audio tape, large print

Please contact BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS at 1-844-783-5189 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. – 8 p.m. local time, seven days a week. TTY users should call 1-800-955-8770.

STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS. 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.

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 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): |__|__| |__|__| |__|__|__|__|
- ❍ 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ❍ I get extra help paying for Medicare prescription drug coverage.
- ❍ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date): |__|__| |__|__| |__|__|__|__|
- ❍ 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 belong to a pharmacy assistance program provided by my state.
- ❍ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❍ 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): |__|__| |__|__| |__|__|__|__|

If none of these statements applies to you or you're not sure, please contact BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS at 1-800-876-2227 (TTY users should call 1-800-955-8770) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m. local time, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on Saturdays, Sundays and Federal holidays.

Please Read and Sign Below:

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

BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS 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. 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.

BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS serves a specific service area. If I move out of the area that BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS 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 BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS 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.

I understand that beginning on the date BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS coverage begins, I must get all of my health care from BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS and other services contained in my BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUEMEDICARE PREFERRED, BLUEMEDICARE PREFERRED HMO OR BLUEMEDICARE PREFERRED POS 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 BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS, he/she may be paid based on my enrollment in BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS.

Release of Information: By joining this Medicare health plan, I acknowledge that BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueMedicare Preferred, BlueMedicare Preferred HMO or BlueMedicare Preferred POS 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: |___|___| |___|___| |___|___|___|___|
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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:	
Name of staff member/agent/broker (if assisted in enrollment): _____	Entity Name: _____
Plan ID #: _____	Five digit Entity ID number (if known):|___|___|___|___|___|
Effective Date of Coverage: _____	Date Received by agent: _____
ICEP/IEP: _____ AEP:_____ SEP (type): _____ Not Eligible:	Florida Blue Agent ID #: _____
PCP National Provider ID (NPI) #: _____	Agent State License #: _____
	Agent Confirmation #: _____