BlueCross BlueShield of North Carolina

PO Box 17168
Winston Salem, NC 27116-7168

BlueMedicare HMOSM
BlueMedicare PPOSM

MedicareRx Prescription Drug Coverage

2016 Individual Enrollment Form for Medicare Advantage Plan

Please contact BCBSNC if you need information in another language or format (Braille).

A. To enroll in BCBSNC, please provide the following:

First Name *Middle Initial* *Last Name* *Jr., Sr.*

Birth Date (MM/DD/YYYY) / /

Sex
☐ Male
☐ Female

Home Phone Number - -

Permanent Residence Street Address *(P.O. Box is not allowed)*

City State Zip Code

County

Alternate Phone Number *(Optional)* - -

Mailing Address *(only if different from your permanent residence address)*

City State Zip Code

Emergency Contact *(Optional)*

Relationship To You

Phone Number - -

B. Please provide your Medicare insurance information

Please take out your Medicare card and 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.

MEDICARE HEALTH INSURANCE

Medicare Claim Number

Is EntitledTo: Effective Date (MM/DD/YYYY)

Hospital (Part A): / /

Medical (Part B): / /

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

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C. Please check which plan you want to enroll in

Please see below for a complete list of counties for each plan.

Blue Medicare HMO Plans

☐ Medical only.....$ 0.00 per month
Available in 85 counties

☐ Standard.....$ 38.40 per month
Available in 74 counties

☐ Enhanced .....$ 64.70 per month
Available in 50 counties

☐ Essential .....$ 76.90 per month
Available in 11 counties

Blue Medicare PPO Plan

☐ Enhanced ..... $ 71.50 per month
Available in 62 counties

Make sure the plan you chose is available in the county in which you live:

Blue Medicare HMO Medical Only

Alamance	Carteret	Forsyth	Hyde	New Hanover	Rockingham	Washington
Alexander	Caswell	Franklin	Iredell	Northampton	Rowan	Watauga
Alleghany	Catawba	Gaston	Johnston	Onslow	Sampson	Wayne
Anson	Chatham	Gates	Jones	Orange	Scotland	Wilkes
Ashe	Chowan	Granville	Lee	Pamlico	Stanly	Wilson
Avery	Cleveland	Greene	Lincoln	Pender	Stokes	Yadkin
Beaufort	Columbus	Guilford	Madison	Perquimans	Surry	Yancey
Bertie	Cumberland	Halifax	Martin	Person	Transylvania	
Bladen	Davidson	Harnett	McDowell	Pitt	Tyrrell	
Brunswick	Davie	Haywood	Mecklenburg	Polk	Union	
Buncombe	Duplin	Henderson	Mitchell	Randolph	Vance	
Cabarrus	Durham	Hertford	Montgomery	Richmond	Wake	
Caldwell	Edgecombe	Hoke	Nash	Robeson	Warren	

Blue Medicare HMO Standard

Alexander	Caldwell	Edgecombe	Hertford	Mitchell	Pitt	Union
Alleghany	Carteret	Franklin	Hoke	Montgomery	Polk	Vance
Anson	Caswell	Gaston	Hyde	Nash	Randolph	Warren
Ashe	Catawba	Gates	Johnston	New Hanover	Richmond	Washington
Avery	Chatham	Granville	Jones	Northampton	Robeson	Watauga
Beaufort	Chowan	Greene	Lee	Onslow	Rockingham	Wayne
Bertie	Cleveland	Guilford	Lincoln	Orange	Sampson	Wilson
Bladen	Columbus	Halifax	Madison	Pamlico	Scotland	Yancey
Brunswick	Cumberland	Harnett	Martin	Pender	Stanly	
Buncombe	Duplin	Haywood	McDowell	Perquimans	Transylvania	
Cabarrus	Durham	Henderson	Mecklenburg	Person	Tyrrell	

Blue Medicare HMO Enhanced

Alexander	Caldwell	Durham	Halifax	Madison	Polk	Wayne
Alleghany	Carteret	Edgecombe	Haywood	Martin	Robeson	Yancey
Ashe	Catawba	Franklin	Henderson	Nash	Rockingham	
Avery	Chatham	Gaston	Hertford	New Hanover	Sampson	
Beaufort	Chowan	Gates	Hyde	Northampton	Scotland	
Bertie	Cleveland	Granville	Johnston	Orange	Vance	
Bladen	Columbus	Greene	Jones	Pender	Warren	
Buncombe	Cumberland	Guilford	Lee	Person	Watauga	

Blue Medicare HMO Essential

Alamance	Davie	Iredell	Stokes	Wake	Yadkin
Davidson	Forsyth	Rowan	Surry	Wilkes	

Blue Medicare PPO Enhanced

Alamance	Caldwell	Davidson	Henderson	Mecklenburg	Richmond	Wake
Alexander	Carteret	Duplin	Hertford	Mitchell	Robeson	Warren
Anson	Caswell	Edgecombe	Hoke	Nash	Rockingham	Washington
Beaufort	Catawba	Forsyth	Iredell	Onslow	Rowan	Watauga
Bertie	Chatham	Gaston	Jones	Orange	Sampson	Wayne
Bladen	Chowan	Gates	Lee	Person	Scotland	Wilkes
Brunswick	Cleveland	Guilford	Madison	Pitt	Stokes	Wilson
Buncombe	Columbus	Harnett	Martin	Polk	Surry	Yancey
Cabarrus	Cumberland	Haywood	McDowell	Randolph	Transylvania	

D. Please choose the name of a Primary Care Physician (PCP)

Name of Primary Care Physician

Physician Address

City State Zip Code

PCP Code (NPI #) (in Provider Directory) PCP Phone

☐ Current patient ☐ New patient

E. Paying your plan premium

Zero Premium Plans: 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 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.

Plans with premiums: You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe by mail 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.

Zero Premium and Plans with premiums: 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 BCBSNC the Part D-IRMMA.

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 the 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. You must continue to pay your Medicare Part B premium.**

Please select a premium payment option

☐ Get a bill each month.

☐ 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.)

F. Please read and answer these important questions

☐ Yes
☐ No

1. Do you have End Stage Renal Disease (ESRD)? 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.

☐ Yes
☐ No

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 Medicare HMO or Blue Medicare PPO. **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 _____

☐ Yes
☐ No

3. Are you enrolled in your State Medicaid program? **If "yes"** please provide your Medicaid number. ☐☐☐☐☐☐☐☐

G. Please read this important information

If you currently have health coverage from an employer or union, joining Blue Medicare HMO or Blue Medicare PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Medicare HMO or Blue Medicare PPO. 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.

H. 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.

☐ AEP (Annual Enrollment Period). Your effective date will be January 1.

☐ I am new to Medicare. Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

☐ I recently moved outside the service area for my current plan **or** I recently moved and this plan is a new option for me. I moved on: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

☐ I get extra help paying for Medicare prescription drug coverage.

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

☐ I no longer qualify for extra help paying for my Medicare prescription drugs.

I stopped receiving extra help on: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

☐ 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 out of the facility on:

☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

☐ I recently left a PACE program on: ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ I am leaving employer or union coverage on: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ I belong to a pharmacy assistance program provided by my state.
☐☐ / ☐☐ / ☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ I recently returned to the United States after living permanently outside of the U.S..
I returned to the U.S. on: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
My plan is ending on: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

My plan is with: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ 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
☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ None of these statements applies to me.*

Other SEP reason: _____

* Please contact BCBSNC at **1-800-665-8037** (TTY users should call **1-800-922-3140**) to see if you are eligible to enroll. We are open 8 a.m. - 8 p.m., 7 days a week.

I. Applicant Agreement

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,** 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.

Your Signature _____ Today's Date ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

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

Name

Address

City State Zip Code

Telephone Number Relationship to Enrollee

If you prefer us to send you information in a language other than English or in another format (e.g., Braille, audio tape or large print): Please contact BCBSNC at **1-800-665-8037**. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-922-3140**.

LICENSED AGENT USE ONLY

Agents must submit a signed enrollment form within 24 hours of receipt.

Agent's Signature _____

Print Agent's Name _____

Date App Received ☐☐ / ☐☐ / ☐☐☐☐ (MM/DD/YYYY)

Telephone Number _____ NPN# (required) _____

Agent Number _____

Statement of Understanding

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

1. Blue Cross and Blue Shield of North Carolina is a an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal. 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.
2. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
3. I understand that if I do not 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.
4. 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.
5. BCBSNC serves a specific service area. If I move out of the area that BCBSNC serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
6. Once I am a member of BCBSNC, I have the right to appeal plan decisions about payment or services if I disagree.
7. I will read the Evidence of Coverage from BCBSNC when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
8. 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.
9. Blue Medicare HMO members only. I understand that beginning on the date Blue Medicare HMO coverage begins, I must get all of my health care from BCBSNC participating providers, except for emergency or urgently needed services or out-of-area dialysis services.

   Blue Medicare PPO members only: I understand that beginning on the date Blue Medicare PPO 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, BCBSNC provides refunds for all covered benefits, even if I get services out-of-network.
10. Services authorized by Blue Medicare HMO and Blue Medicare PPO and other services contained in my Blue Medicare HMO and Blue Medicare PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE MEDICARE HMO AND BLUE MEDICARE PPO WILL PAY FOR THE SERVICES**.
11. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BCBSNC he/she may be paid based on my enrollment in BCBSNC.
12. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information

1. By joining this Medicare health plan, I acknowledge that BCBSNC will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
2. I also acknowledge that BCBSNC 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.
3. 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.