2020 Individual Enrollment Request Form

Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO), or Blue Shield Vital (HMO)

blue california

Please contact Blue Shield of California if you need information in another language or format (large print).

Please fax or mail your completed enrollment form to:

Fax: (877) 251-3660
Mail: Blue Shield of California,
PO Box 948, Woodland Hills, CA 91365-9856

To enroll in Blue Shield 65 Plus℠, Blue Shield 65 Plus℠ Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital, please provide the following information:

Please check which plan you want to enroll in, based on where you live:

- ☐ Blue Shield 65 Plus – Los Angeles/Orange counties ($0 per month)
- ☐ Blue Shield 65 Plus Choice Plan – Los Angeles*/Orange counties ($0 per month)
- ☐ Blue Shield 65 Plus Choice Plan – San Bernardino/Riverside counties ($0 per month)
- ☐ Blue Shield 65 Plus – Fresno County ($20 per month)
- ☐ Blue Shield 65 Plus – Kern County ($0 per month)
- ☐ Blue Shield 65 Plus – Riverside County ($0 per month)
- ☐ Blue Shield Trio Medicare – Sacramento County ($39 per month)
- ☐ Blue Shield 65 Plus – San Bernardino County ($0 per month)
- ☐ Blue Shield 65 Plus – Santa Barbara*/San Luis Obispo* counties ($0 per month)
- ☐ Blue Shield 65 Plus – San Diego County ($0 per month)
- ☐ Blue Shield 65 Plus – Ventura County ($0 per month)
- ☐ Blue Shield Inspire – Alameda County ($65 per month)
- ☐ Blue Shield Inspire - San Mateo County ($55 per month)
- ☐ Blue Shield Inspire - Los Angeles/Orange counties ($0 per month)
- ☐ Blue Shield Vital - Los Angeles/Orange counties ($0 per month)
- ☐ Blue Shield Vital – San Bernardino/Riverside counties ($0 per month)

* See the Summary of Benefits for covered ZIP codes.

Please indicate if you would like to enroll in the Optional Supplemental Dental HMO or PPO plan

☐ Optional Supplemental Dental HMO plan ($11.60 per month)
(not available in Santa Barbara/San Luis Obispo counties)

Name of dentist

Provider ID#

If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

☐ Optional Supplemental Dental PPO plan ($37.90 per month)
No dentist selection necessary for the PPO plan.

Last Name

☐ Mr. ☐ Mrs. ☐ Ms.

First Name

Middle Initial

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):

Street Address

City | State | ZIP code

Mailing Address (only if different from your Permanent Residence Address):

Street Address

City | State | ZIP code

Email Address

☐ I am willing to receive required plan materials via email (i.e. enrollment notifications and Annual Notice of Changes) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via email (i.e., benefit promotions, and event invitations, and plan newsletter) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

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

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe, and the Optional Supplemental Dental HMO or PPO plan premium, if you enrolled in that plan) by mail or by "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 RRB. DO NOT pay Blue Shield of California 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 monthly bill.

☐ 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 anymore, **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 Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital?

☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Prescription drug coverage

Name of other coverage:

ID # for this coverage:

Group #:

Medical coverage

Name of other coverage:

ID # for this coverage:

Group #:

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 and Phone Number of Institution (number and street):

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4. Are you enrolled in your State Medicaid program (Medi-Cal)? ☐ Yes ☐ No

If "yes," please provide your Medicaid (Medi-Cal) number:

5. Do you or your spouse work? ☐ Yes ☐ No

Choose a Primary Care Physician and Physician Group

Physician Name:

Physician ID #:

Current Patient? ☐ Yes ☐ No

Physician Group Name:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ Spanish ☐ Large Print

Please contact Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital at **(800) 776-4466** [TTY users should call **711**] if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30.

Please read this important information

If you currently have health coverage from an employer or union, joining Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital. 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: Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, and Blue Shield Vital are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in 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.

Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, and Blue Shield Vital serve specific service areas. If I move out of the area that Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, and Blue Shield Vital serve, 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 Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, and Blue Shield Vital, 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 Shield 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 Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital coverage begins, I must get all of my health care from Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital and other services contained in my Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, and Blue Shield Vital *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS, BLUE SHIELD 65 PLUS CHOICE PLAN, BLUE SHIELD TRIO MEDICARE, BLUE SHIELD INSPIRE, OR BLUE SHIELD VITAL 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 Blue Shield of California, he/she may be paid based on my enrollment in Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, or Blue Shield Vital.

Release of Information: By joining this Medicare health plan, I acknowledge that Blue Shield of California will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Shield of California 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 legally authorized representative (i.e., power of attorney or legal guardian – see description above), you must sign above and provide the following information:

Name:

Address:

Phone Number:

Relationship to Enrollee:

Producer information: Producer name and ID or NPN **is required**.

FMO/Agency name: _____
(please print appointed agency name)

FMO/Agency ID #: _____
(please print agency ID)

Producer name: _____
(please print writing agent name)

Producer ID #: _____
(please print agent ID number or NPN)

Producer NPN #: _____
(please print NPN number)

Producer phone number: _____

Producer email address: _____

Date application received by producer: _____

Producer signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

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 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 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 both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ 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 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 qualifications required to be in the plan. I was disenrolled from the SNP on (insert date).

		/			/				

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Blue Shield Member Services at **(800) 776-4466** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30.