

# 2018 Enrollment Request Form Blue Shield 65 Plus (HMO) Employer Group/Union Health Plan

Please contact Blue Shield 65 Plus if you need information in another language or format (large print).

## To enroll in Blue Shield 65 Plus, please provide the following information:

Employer group or union name \_\_\_\_\_ Group or union No. \_\_\_\_\_  
(leave blank if not provided by your employer group or union)

Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
-----------	------------	----------------	---

Birth date (__ __ / __ __ / __ __ __ __) (MM / DD / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ( )	Alternate phone number ( )
--	---	--------------------------	-------------------------------

### Permanent residence (no P.O. boxes)

Street address \_\_\_\_\_

City	State	ZIP code
------	-------	----------

### Mailing address (only if different from your permanent residence address)

Street address \_\_\_\_\_

City	State	ZIP code
------	-------	----------

Emergency contact (optional)	Relationship to you (optional)	Phone number (optional) ( )
------------------------------	--------------------------------	--------------------------------

Email address (optional) \_\_\_\_\_

- I am willing to receive required plan materials via email (i.e., enrollment notifications, the Annual Notice of Changes and *Evidence of Coverage*, and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations) 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: \_\_\_\_\_ Sex \_\_\_\_\_

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.**

H0504\_17\_204A 07262017

---

**Please read and answer these important questions**

---

1. Are you the retiree?  Yes  No

If yes, retirement date (month/date/year) \_\_\_\_\_

If no, name of retiree \_\_\_\_\_

---

2. Are you covering a spouse or dependent(s) under this employer group or union plan?

Yes  No

If yes, name of spouse\* \_\_\_\_\_

Name of dependent(s) \_\_\_\_\_

---

\* If your spouse and any of the covered dependents listed above are eligible for Medicare, please ensure that each complete and return an enrollment form.

---

3. Do you or your spouse work?  Yes  No

---

4. 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.

---

5. Some individuals may have other coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Blue Shield 65 Plus?

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 No. for this coverage \_\_\_\_\_ Group No. \_\_\_\_\_

**Medical coverage**

Name of other coverage \_\_\_\_\_

ID No. for this coverage \_\_\_\_\_ Group No. \_\_\_\_\_

---

6. 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) \_\_\_\_\_

---

---

---

**Please choose a Primary Care Physician (PCP) and affiliated medical group**

---

Your physician choice name

---

Physician ID No.

---

Name of medical group affiliated with your physician choice

---

Are you already a patient of this physician?  Yes  No

---

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:  Spanish  Large print

---

Please contact Blue Shield 65 Plus at **(800) 776-4466** [TTY **711**] if you need information in another format or language. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1 through February 14, and 8 a.m. to 8 p.m., weekdays, from February 15 through September 30.

---

**Please read and sign below**

---

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

Blue Shield 65 Plus 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 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. 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 if an enrollment period is available (for example, during your former employer group/union's open enrollment period, or during the Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Blue Shield 65 Plus serves a specific service area. If I move out of the area that Blue Shield 65 Plus 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 Shield 65 Plus, 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 65 Plus 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 coverage begins, I must get all of my health care from Blue Shield 65 Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus and other services contained in my Blue Shield 65 Plus *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 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 65 Plus, he/she may be paid based on my enrollment in Blue Shield 65 Plus.

---

---

**Release of information**

---

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield 65 Plus 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.

---

Enrollee signature

---

Today's date

**If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information**

Name	Address
Phone number (     )	Relationship to enrollee

**Please return your completed enrollment form to your Benefits Administrator or mail to:**

Blue Shield 65 Plus  
P.O. Box 948  
Woodland Hills, CA 91365

**Office use only:**

Name/signature of staff member/agent/broker (if assisted enrollment)

---

Plan ID No. \_\_\_\_\_

Effective date of coverage \_\_\_\_\_

ICEP/IEP \_\_\_\_\_ AEP \_\_\_\_\_

SEP (type) \_\_\_\_\_ Not eligible \_\_\_\_\_