Blue Cross MedicareRx℠
Medicare Prescription Drug Plan Individual Enrollment Form

BlueCross of California

Step 1: Please provide information about you. (Please print clearly.)					
Last name	First name		MI	☐ Mr. ☐ Mrs. ☐ Ms.	
Permanent residence street address	City			State	ZIP code
Social Security number (optional)	Date of birth ____/____/____	Sex ☐ Male ☐ Female	Home phone number ( )		
Mailing address (only if different from your permanent residence address)					
Street/P.O. Box	City			State	ZIP code

Step 2: Please select a Benefit Plan – Choose only one.

☐ Blue Cross MedicareRx Value	☐ Blue Cross MedicareRx Plus	☐ Blue Cross MedicareRx Gold
Monthly Premium $20.04	Monthly Premium $28.56	Monthly Premium $35.29

Step 3: 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

Name ______________________________

Medicare Claim Number Sex ____

__ __ __ - __ __ - __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) ________________

MEDICAL (Part B) ________________

Step 4: Please read this important information.

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Blue Cross MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Blue Cross MedicareRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue Cross MedicareRx may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Step 5: Please select your plan premium payment option.

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail or automatic withdrawal from your bank account. If you choose to make monthly payment by automatic withdrawal from your bank account, please complete the enclosed Automatic Payment Option form. Generally you must stay with the option you choose for the rest of the year.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the difference, if there is any, deducted from your monthly check.

Would you like the premium for this prescription drug plan deducted from your SSA monthly benefit check? ☐ **Yes** ☐ **No**

Step 6: Please answer the following questions to help Medicare coordinate your benefits.

1. 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 MedicareRx? ☐ **Yes** ☐ **No** *If yes, please list your other coverage and your identification (ID) number(s) for this coverage.*

Name of other coverage ______________________________

ID number ______________________ Group number ______________________

2. 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 of Institution ______________________________

Phone number of Institution (________) ______________________

Step 7: Please read and sign below.

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

Blue Cross MedicareRx is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Blue Cross MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue Cross MedicareRx or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Blue Cross MedicareRx serves a specific service area. If I move out of the area that Blue Cross MedicareRx 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 MedicareRx, 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 MedicareRx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Blue Cross MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) 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 by Blue Cross MedicareRx or by Medicare.

Your Signature* ______________________________ **Today's Date** ______________

**If you are the authorized representative, you must provide the following information:*

Name ______________________________ Address ______________________________

Phone number ______________________________ Relationship to Enrollee ______________________________

If anyone helped the individual fill out this form, he or she must sign below:

Signature ______________________________ **Relationship** ______________ **Date** ______________

Medicare Prescription Drug Plan Use Only: Plan ID#

Effective Date of Coverage ______________________________ IEP ________ AEP________ SEP (type) ______________

Agent Signature** ______________________________ Agent Number **LJKFJSSLNZ**

Broker Signature** ______________________________ Code Number ______________

I have assisted the applicant in filling out this application. ☐ **Yes ☐ **No**

Jeffrey D. Peterson
http://insurancecowboy.com
Fax completed to 1-866-303-9525
1-800-655-9525
LJKFJSSLNZ

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