Florida Blue

BlueMedicare[SM] Group PPO

A Medicare Advantage Health Care Plan for Groups

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

Employer/Union Group Health Plan Enrollment Form

Please contact BlueMedicare Group PPO if you need information in another language or format (e.g. Spanish, Braille, Audio, Large Print).

1. To Enroll in BlueMedicare PPO please provide the following information:

Please check your desired Prescription Drug Plan **(CHECK ONE):** ❍ PPO1 RX1 ❍ PPO1 RX2 ❍ PPO1 RX3 ❍ PPO2 RX1 ❍ PPO2 RX2 ❍ PPO2 RX3

Include dental/hearing/vision package ❍ Yes ❍ No

Full Name of Employer/Union:

Group # ____________ Location Code |___ ___ ___ ___| Group Renewal Date|___ ___| |___ ___| |___ ___ ___ ___| (M M D D Y Y Y Y)

Requested Effective Date of Coverage: |___|___| |_0_|_1_| |___|___|___|___| (M M D D Y Y Y Y)

Employee ID # (if available):

Last Name: First Name: Middle Initial: ❍ Mr. ❍ Mrs. ❍ Ms.

Permanent Residence Street Address (P.O. Box is **NOT** allowed): Apt/Unit/Route #

City | State | Zip

Birth Date |___|___| |___|___| |___|___|___|___| (M M D D Y Y Y Y) Gender ❍ M ❍ F

Home Phone |___|___|___|–|___|___|___|–|___|___|___|___| Alt. Phone |___|___|___|–|___|___|___|–|___|___|___|___|

Please provide a **Mailing address** (where all communications except your bill are sent) if different from your Permanent Residence Address.

Address | Apt/Unit/Route #

City | State | Zip

What is your preferred method of communication? ❍ Phone ❍ Mail ❍ E-mail

❍ By checking here, I request that Florida Blue send me plan materials and customer communications via e-mail when these services and materials are available. I understand that I may receive invitations to participate in research activities and that I may choose to opt out of any of these services at any time by contacting Florida Blue's Member Services Department.

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.

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2. Please read and answer these important questions:

1. Are you the retiree? ❍ Yes ❍ No

If "yes," what is your retirement date?: |___|___| |___|___| |___|___|___|___| (M M D D Y Y Y Y) If no, name of retiree: ______________________

2. Are you covering a spouse or dependents under this employer or union plan? ❍ Yes ❍ No

If "yes," name of spouse: ______________________ Name of dependents:_____ ______________________

3. Do you work? ❍ Yes ❍ No | Does 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 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.

5. Some individuals may have other health and/or drug coverage, including other private insurance, Worker's Compensation, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to BlueMedicare Group PPO? ❍ Yes ❍ No

If "yes," please provide the following information:
Name of Carrier: ______________________
Address: ______________________ Phone #: ______________________
Policy Holder: ______________________
Type of Coverage:
❍ Group ❍ Supplemental ❍ Excess ❍ Private (self pay) ❍ Life ❍ Veterans Affairs (VA)
ID#: __________ Group# (if applicable): __________ Effective Date: __________ Term Date: __________

Will you have other **health** coverage in addition to BlueMedicare Group PPO? ❍ Yes ❍ No

If "yes," please provide the following information:
Name of Carrier: ______________________
Address: ______________________ Phone #: ______________________
Policy Holder: ______________________
Type of Coverage:
❍ Group ❍ Supplemental ❍ Excess ❍ Private (self pay) ❍ Life ❍ Veterans Affairs (VA)
ID#: __________ Group# (if applicable): __________ Effective Date: __________ Term Date: __________

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: ______________________
Phone Number of Institution: ______________________

7. **Please provide the name of your Physician of Choice (POC)**. A POC is a physician that you **choose** to see for most health reasons. If you wish to change to a different POC after becoming active in this plan, you may contact our Member Services Department.

POC First Name POC Last Name
__________ __________
POC's FL Blue Provider ID Number
|___|___|___|___|___| - |___| (ie: 12345 or 12345A)
POC's 10-digit National Provider ID (NPI)
Number |___|___|___|___|___|___|___|___|___|___|
Are you currently a patient of this POC?
❍ Yes ❍ No

Physician Group Name
____
Physician Group's FL Blue Provider ID Number
|___|___|___|___|___| - |___| (ie: 12345 or 12345A)
Physician Group's 10-digit National Provider ID (NPI)
Number |___|___|___|___|___|___|___|___|___|___|
Are you currently a patient of this Physician Group?
❍ Yes ❍ No

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**.

Please contact BlueMedicare Group PPO at 1-800-926-6565 if you would prefer us to send you information in a language other than English or in another format (e.g. Spanish, Braille, Audio, Large Print). Our Member Services Department is open from 8:00 a.m. - 9:00 p.m. ET, seven days a week. TTY users should call 1-800-955-8771.

If you are currently covered under a **Florida Blue Medicare Supplement** policy, do you intend to replace your current coverage with this new Florida Blue Medicare Advantage plan? ❍ Yes ❍ No

❍ By checking here, you request Florida Blue to cancel your **Florida Blue Medicare Supplement** policy on the day before this Medicare Advantage plan becomes effective. For Example, Florida Blue BlueMedicare Group PPO plan is effective July 1st; Florida Blue will cancel your **Florida Blue Medicare Supplement** policy effective June 30th.

To ensure accurate processing, you must provide your **Florida Blue Medicare Supplement**

Policy ID Number: I_H_I___I___I___I___I___I___I___I___I - I___I___I (example: H12345678 01)

3. Please Read and Sign on the Next Page:

<u>By completing this enrollment application, I agree to the following:</u>

I understand that health and prescription insurance is offered by Florida Blue. Florida Blue is a trade name for Blue Cross and Blue Shield of Florida, an Independent Licensee of the Blue Cross and Blue Shield Association.

Please keep in mind that BlueMedicare Group PPO is not a Medicare Supplement plan. Florida Blue is a PPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal. 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 if an enrollment period is available, generally during the Medicare Annual Enrollment Period (October 15 - December 7 of every year) or during the Group Annual Open Enrollment Period, unless I qualify for certain special circumstances.

BlueMedicare Group PPO serves a specific service area. If I move out of the area that BlueMedicare Group PPO serves, I need to notify the plan so I can disenroll. Once I am a member of BlueMedicare Group PPO, 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 Group PPO 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. However, once I am a member of BlueMedicare Group PPO, I will have coverage worldwide for emergencies outside the United States.

I understand that beginning on the date BlueMedicare Group PPO coverage begins, I must get all of my health care from BlueMedicare Group PPO, except for emergency or urgently needed services or out-of-area dialysis services. BlueMedicare Group PPO provides payment for all medically necessary covered services minus the amount of your required plan cost-sharing, even if you get services out of network. Services authorized by BlueMedicare Group PPO and other services contained in my BlueMedicare Group PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Prior authorization is required only for certain services (refer to your Evidence of Coverage). Without authorization, neither Medicare nor BlueMedicare Group PPO 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 Group PPO, he/she may be paid based on my enrollment in BlueMedicare Group PPO.

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Release of Information:

By joining this Medicare prescription plan, I acknowledge that BlueMedicare Group PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueMedicare Group PPO 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. I acknowledge that my information described herein may be disclosed to other entities with which BlueMedicare Group PPO has contracted to perform certain services on its behalf (business associates). I further acknowledge that information released by BlueMedicare Group PPO may, if applicable, include my medical and payment information relating to HIV/AIDS, mental health and substance abuse diagnosis and treatment. This release is for the plan year of 2018, January 1, 2018 to December 31, 2018 and for three years following the plan year of 2018 in order that BlueMedicare Group PPO may complete any required data submission, bids, claims processing, and other similar activities for which my information is necessary. 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 law 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 by Medicare.

Signature: X✍ ______________________ **Today's Date:** |___|___| |___|___| |___|___|___|___|
M M D D Y Y Y Y

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

Name: ______________________ **Phone Number:** |_|_|_|–|_|_|_|–|_|_|_|_|

Address: ______________________

Relationship to Enrollee: ______________________

This information is optional and is for data collection only.
It will not be used to determine eligibility or claim payment.

Ethnicity/Race (check all that apply):

❍ Asian or Pacific Islander
❍ Black or African American
❍ Caribbean Islander
❍ Hispanic
❍ Native American
❍ White

Language of Preference

❍ English ❍ Spanish

Office Use Only (If assisted with enrollment):

Name of Agent:_ ______________________

Florida Blue Agent ID #: |___|___|___|___|___|___|___|

Agent's State License #: |___|___|___|___|___|___|___|___|___|___|

Agent Confirmation #: ______________________

Plan ID #: _ ______________________

❍ ICEP/IEP
❍ AEP
❍ SEP

Date received by Agent:

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