Medicare PLUS Blue PFFS℠

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Medicare Plus Blue PFFS is a health plan with a Medicare contract.

2010

INDIVIDUAL ENROLLMENT FORM

Medical and Prescription Drug Coverage (Coverage Effective 2010)

Office Use Only:

Please contact Medicare Plus Blue PFFS if you need information in another language or Braille.
Do not send a payment with this application. You will be billed at a later date.

Sec. I To enroll in Medicare Plus Blue PFFS, please provide the following information:

Check which option you want to enroll in: (See premium table on other side of this form.)

Region (See counties on Premium Table)	Option A	Option B
Region 1: Southwest Michigan	☐ $81	☐ $116
Region 2: Mid-Michigan	☐ $114	☐ $162
Region 3: Upper Michigan	☐ $153	☐ $208
Region 4: South Michigan	☐ $140	☐ $191
Region 5: North/East Michigan	☐ $182	☐ $229
Region 6: Southeast Michigan	☐ $172	☐ $248

☐ Mr. ☐ Mrs. ☐ Ms. | First Name | Middle Initial | Last Name

Birth Date (/ /) (M M / D D / Y Y Y Y) | Sex ☐ Male ☐ Female | Home Phone Number ( ) | Alternate Phone Number ( )

E-mail Address (Providing e-mail address allows for future communications) | Permanent Residence Street Address (No P.O. Box)

City | State | Zip Code | County

Mailing Address (Only if different from your permanent residence street address)

Street Address ____________________

City ____________________ State ________ Zip Code ________

OPTIONAL INFORMATION

Emergency Contact Name ____________________

Relationship to You ____________________ **Phone Number** ( ) ________

Sec. II Please provide your Medicare insurance information.

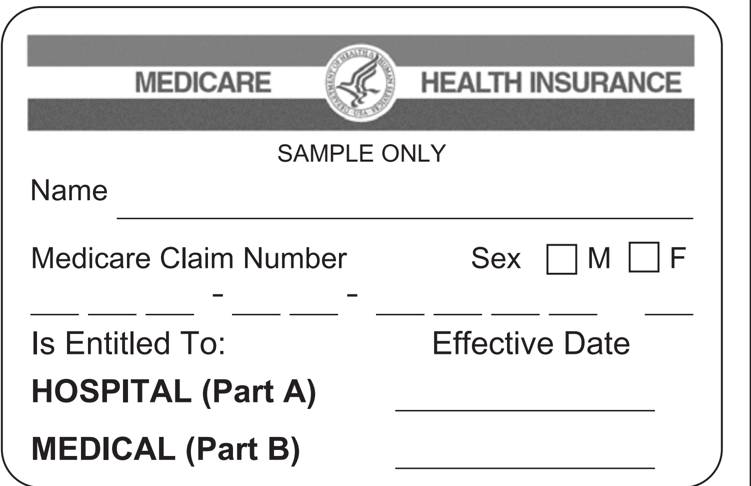
Please take out your Medicare card to complete this section.

- 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 the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan such as Medicare Plus Blue PFFS


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ____________________

Medicare Claim Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___ Sex ☐ M ☐ F

Is Entitled To: Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

Mail-White Copy **Keep-Yellow Copy**

Sec. III Information to determine enrollment periods

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can also join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 dissenrolled.

☐ I am new to Medicare.
☐ 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. Date of Move:_ _ / _ _ / _ _ _ _
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
☐ I recently "left" a PACE program. Date: _ _ / _ _ / _ _ _ _
☐ 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). Effective Date: _ _ /_ _ /_ _ _ _
☐ I recently involuntarily lost my credible drug coverage (coverage as good as Medicare's). Date of Loss: _ _ / _ _ / _ _ _ _
☐ I am leaving employer or union coverage. Effective Date: _ _ / _ _ / _ _ _ _
☐ I belong to a pharmacy assistance program provided by my state.
☐ I recently returned to the United States after living permanently outside of the U.S. Date of Return: _ _ / _ _ / _ _ _ _
☐ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan for the first time (*Medicare Advantage plan with prescription drug coverage).
☐ In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
☐ I am currently receiving extra help paying for Medicare prescription drug coverage but do not have Medicaid.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. Effective Date: _ _ / _ _ / _ _ _ _
☐ My plan is ending its contract with Medicare. Effective Date: _ _ /_ _ / _ _ _ _
☐ I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
☐ I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.
☐ I received a notice from my plan or Medicare telling me that I am eligible for a Special Enrollment Period.
☐ I get extra help paying for Medicare prescription drug coverage.
☐ I am eligible to join or leave a Medicare Advantage Plan. Note: Open Enrollment Period only Effective Date: _ _ / _ _ / _ _ _ _
☐ Other Reason provided to me by a Medicare Official:____________________
☐ None of these statements applies to me.*

* Please contact Medicare Plus Blue PFFS at 800-485-4415 (TTY users should call 800-481-8704) to see if you are eligible to enroll. We are open seven days a week, from 8 AM to 8 PM.

Sec. IV Paying your plan premium

You can pay your monthly plan premium by mail or automatic withdrawal from your bank account each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month. 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 800-772-1213. TTY users should call 800-325-0778. You can also apply for extra help online at socialsecurity.gov/prescriptionhelp.

Sec. IV Continued — **Paying your plan premium**

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. Check **only one** box.

☐ **1)** Bill me on a monthly basis.

☐ **2)** Automatic deduction from my monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

☐ **3)** Electronic funds transfer (EFT) from my bank account each month. Please enclose a VOIDED check or savings deposit slip and provide the following:

Account Holder Name:______________________________

Bank Routing Number: _ _ _ _ _ _ _ _ _ Bank Account Number:______________________

Account Type: ☐ Checking ☐ Savings

Sec. V — **Please read and answer the following important questions**

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 Medicare Plus Blue PFFS? ☐ Yes ☐ No
If "Yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID No. for this coverage:	Group No. for this coverage:

2. Are you a resident in a long term care facility, such as a nursing home? ☐ Yes ☐ No

If you answered "yes", please provide the following information.

Name of Facility			
Address			
City	State	Zip Code	Phone Number

3. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant to:

Medicare Plus Blue PFFS
P.O. Box 440, Southfield, MI 48037

Note: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Blue Cross Blue Shield of Michigan organization as a commercial member or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998.

4. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

If you answered "yes", please provide your Medicaid Number: ______________________

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

Sec. VI Please read and answer if needed

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 ☐ Braille

Please contact Medicare Plus Blue at 800-485-4415 if you need information in another format or language than what is listed above. Our office hours are seven days a week, from 8 AM to 8 PM. TTY users should call 800-481-8704

Agent/Office Use Only: (Applicant does not need to complete this section).

Note to Agents: 2010 paper enrollment forms must be keyed into **bcbsm.com/agent/** or submitted to the Managing or General Agent within 24 hours of accepting the paper enrollment form.

Date Producing Agent accepted paper enrollment from Medicare Eligible: ☐☐/☐☐/☐☐☐☐

Date Managing or General Agent or Association received paper enrollment form from Producing Agent: ☐☐/☐☐/☐☐☐☐

Name of Managing or General Agent or Association **(print)**: ______________________

Name of Producing Agent (**print** first, last name): ______________________

Signature of Producing Agent: ______________________

2-digit Managing or General Agent or Association Code: ☐☐ **5-digit Producing Agent Code:** ☐☐☐☐☐

I assisted the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of *person entering enrollment information online* (**print** first, last name): ______________________

BCBSM Source Code: ☐ BCBSM Badge # : E☐☐☐☐☐☐

Sec. VII Please Read this Important Information

Medicare Plus Blue PFFS, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept Medicare Plus Blue PFFS before each visit. Providers can find the plan’s terms and conditions on our website at bcbsm.com/ma.

Once Medicare Plus Blue PFFS has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private-Fee-for-Service plan works and to confirm your intent to enroll in Medicare Plus Blue PFFS. If Medicare Plus Blue PFFS isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

If you currently have health coverage from an employer or union, joining Medicare Plus Blue PFFS could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Medicare Plus Blue PFFS may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join Medicare Plus Blue PFFS. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.

Sec. VIII Please read

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

Medicare Plus Blue PFFS is a Medicare Private Fee-for-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Medicare 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 if an enrollment period is available (Example: November 15 – December 31 of every year), or under certain special circumstances.

Sec. VIII Continued **Please read and sign below**

As a Medicare Private Fee-for-Service plan, Medicare Plus Blue PFFS works differently than Medicare supplement plan as well as other Medicare Advantage plans. Medicare Plus Blue PFFS pays instead of Medicare, and I will be responsible for the amounts that Medicare Plus Blue PFFS doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in Medicare Plus Blue PFFS.

Before seeing a provider, I should verify that the provider will accept Medicare Plus Blue PFFS. I understand that my health care providers have the right to choose whether to accept Medicare Plus Blue PFFS's payment terms and conditions every time I see them. I understand that if my provider doesn't accept Medicare Plus Blue PFFS, I will need to find another provider that will.

Medicare Plus Blue PFFS serves a specific service area. If I move out of the area that Medicare Plus Blue PFFS serves, I need to notify Medicare Plus Blue PFFS plan so I can disenroll and find a new plan in my new area. Once I am a member of Medicare Plus Blue PFFS I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medicare Plus Blue PFFS when I get it to know which rules I must follow in to get coverage with this Private Fee-for-Service 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medicare Plus Blue PFFS, he/she may be paid based on my enrollment in Medicare Plus Blue PFFS.

Release of Information:

By joining this Medicare health plan, I acknowledge that Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medicare Plus Blue PFFS 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 by Medicare Plus Blue PFFS or by Medicare.

Your Signature	Today's Date

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

Name	Phone Number ( )

Address	City	State	Zip Code

Relationship to Enrollee

Please mail this form to: **Medicare Plus Blue PFFS**
PO Box 440
Southfield, MI 48037

Medicare Plus Blue PFFS Premium Table

The premiums vary by the county in which you permanently reside

(Rates are based on the use and cost of health care services in each region)

1. **Locate the region and county in which you permanently reside.**
2. **Look at the plan options to find your monthly premium rate.**
3. **Check the correct option box on the first page of this application.** (Only one box may be checked.)

Medical and Prescription Drug Coverage

	Monthly Medicare Plus Blue PFFS Premium	
Region with counties	**Option A**	**Option B**
Region 1: Southwest Michigan Allegan, Kent, Muskegon, Newaygo, Ottawa	**$81**	**$116**
Region 2: Mid-Michigan Barry, Berrien, Cass, Clinton, Eaton, Ingham, Ionia, Kalamazoo, Van Buren	**$114**	**$162**
Region 3: Upper Michigan Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iron, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Marquette, Menominee, Montmorency, Ontonagon, Oscoda, Otsego, Presque Isle, Schoolcraft	**$153**	**$208**
Region 4: South Michigan Branch, Calhoun, Hillsdale, Jackson, Lenawee, Livingston, Monroe, St Joseph, Washtenaw	**$140**	**$191**
Region 5: North/East Michigan Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Iosco, Isabella, Lake, Lapeer, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Oceana, Ogemaw, Osceola, Roscommon, Saginaw, Saint Clair, Sanilac, Shiawassee, Tuscola, Wexford	**$182**	**$229**
Region 6: Southeast Michigan Macomb, Oakland, Wayne	**$172**	**$248**