Kansas City | BLUE MEDICARE ADVANTAGE

Enrollment Request Form to Enroll in Blue Medicare Advantage

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?
You can join a plan:

- Between October 15-December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional - you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15-December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Send your completed and signed form to:
Blue Medicare Advantage
PO Box 410080
Kansas City, MO 64141

Once they process your request to join, they'll contact you.

How do I get help with this form?
Call Blue Medicare Advantage at 1-855-208-8246 (TTY: 711).

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En Español: Llame a Blue Medicare Advantage al 1-855-208-8246 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en Español y un representante estara disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. The HMO products are offered by Blue-Advantage Plus of Kansas City, Inc. and the PPO products are offered by Missouri Valley Life and Health Insurance Company, both wholly-owned subsidiaries of Blue Cross and Blue Shield of Kansas City.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

PPO	☐ H6502-004 Blue KC Simply Blue (PPO) – Choose Bundle Option*	$0 per month
	☐ Blue Benefit Bundle **CLASSIC**	
	☐ Blue Benefit Bundle **ACTIVE**	
	☐ Dental Option: ☐ Blue Benefit Bundle **CLASSIC + Buy-up DENTAL PLAN**	$25 per month
	☐ Blue Benefit Bundle **ACTIVE + Buy-up DENTAL PLAN**	$25 per month
	☐ H6502-002 Blue KC Essential (PPO)	$0 per month
	☐ H6502-003 Blue KC Valor (PPO)	$0 per month
	☐ H6502-003 Blue KC Valor (PPO) + **Buy-up DENTAL PLAN**	$25 per month
	☐ H6502-005 Blue KC Giveback (PPO)	$0 per month
HMO	☐ H1352-004 Blue KC Secure (HMO)	$0 per month

Please note: If no selection is indicated CLASSIC BUNDLE is automatic default selection.

FIRST name:	LAST name:	Middle Initial:

Birth date: (MM/DD/YYYY)	Sex:	Phone number:
(__ __/__ __/__ __ __ __)	☐ Male ☐ Female	( )

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

City:	State:	ZIP Code:

Your Medicare information:

Medicare Number __ __ __ __ – __ __ __ __ – __ __ __ __

Answer these important questions:

☐ Yes ☐ No	Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Medicare Advantage?
Name of other coverage:	Member number and Rx PCN/BIN for this coverage (*see your ID card)*:

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IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Medicare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that Blue Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Blue Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Blue Medicare Advantage. Benefits and services provided by Blue Medicare Advantage and contained in my Blue Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Medicare Advantage will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application.
- If signed by an authorized representative (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:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 - All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? **Select all that apply.**

☐ No, not of Hispanic, Latino/a, or Spanish origin

☐ Yes, Mexican, Mexican American, Chicano/a

☐ Yes, Puerto Rican ☐ Yes, Cuban

☐ Yes, another Hispanic, Latino/a, or Spanish origin

☐ **I choose not to answer.**

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What's your race? Select all that apply.

☐ American Indian or Alaska Native American ☐ Asian Indian ☐ Black or African

☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean

☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan

☐ Vietnamese ☐ White ☐ **I choose not to answer**

Select one below if you prefer information in a language other than English.

☐ Spanish ☐ Vietnamese ☐ Chinese

Please contact Blue Medicare Advantage at 816-395-3152 or 855-208-8246 if you need a document translated into a language other than English. Our office hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends and holidays from April 1 through September 30. TTY users can call 711.

Select one if you prefer information in an accessible format. ☐ Large print

Please contact Blue Medicare Advantage at 816-395-3152 or 855-208-8246 if you prefer information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends and holidays from April 1 through September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center (please also include the PCP ID):

Paying your plan Premiums

You can pay your monthly plan premium by mail, (including any late enrollment penalty that you currently have or may owe) Electronic Funds Transfer (EFT), credit card, debit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

☐ Invoice: Check, Credit or Debit Card ☐ Social Security Deduction

☐ Bank Account or EFT ☐ Railroad Retirement Board

If you have to pay a Part D Income Related Monthly Adjustment Amount (Part D IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Medicare Advantage the Part D-IRMAA.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Attestation of Eligibility

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 enrolling in the Annual Enrollment Period.
- ☐ 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 am in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
- ☐ I am newly eligible for Medicare Part B and am enrolling during the Part B General Election Period. I want to join a Medicare Advantage Plan.
- ☐ I have had Medicare prior to now, but I am now turning 65.
- ☐ 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'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical

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- ☐ 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 am new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified of getting Medicare on (insert date) _____.
- ☐ I recently left a PACE (Programs of All-Inclusive Care for the Elderly) 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 (including COBRA) (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) _____.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
- ☐ I dropped a Medicare Supplement Insurance (Medigap) policy when I first joined a Medicare Advantage Plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I'm joining a Drug Plan (Part D). My plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that 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 Medicare Advantage at 1-855-208-8246 (TTY:711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends and holidays from April 1 through September 30.

Producer Name:	**Producer NPN:**	**Application Receipt Date:**