MASSACHUSETTS

Medicare | HMO Blue® (HMO)

To Complete Your Group Enrollment Form:

Be sure to complete all information, sign, and date your enrollment form. Return the completed form(s) to your employer. We will contact you in writing when we receive your enrollment form, and then again to notify you of your effective date of coverage.

To Enroll in Medicare HMO Blue, Please Provide the Following Information:

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

Birth Date: (// / /) (MM/DD/YYYY)
Sex: M F
Home Phone Number: (____) ____ - _______
Alternate Phone Number: (____) ____ - _______

Permanent Residence Address (P.O. Box is not allowed):
Number and Street: ______________________________
City: ______________________ State: ____________ Zip: ________

Mailing Address (only if different from your permanent residence address):
Number and Street: ______________________________
City: ______________________ State: ____________ Zip: ________

Emergency Contact Name: ______________________________
Phone Number: ________ - ________ Relationship to You: ______________________

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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: ______________________________

Medicare Claim Number Sex M F
__ __ __ - __ __ - __ __ __ __

Effective Date

Is Entitled To
HOSPITAL (Part A) ________ / / ________
MEDICAL (Part B) ________ / / ________

Employer Use Only:
Group Name: ______________________ Group Number: ______________________
Requested Effective Date: ______________________

Office Use Only:
ICEP/IEP: ______________ AEP: ______________ SEP (type): ______________

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Please Read and Answer These Important Questions

1. Do you have End Stage Renal Disease (ESRD)? ❑ Yes ❑ No
   If you answered "yes" to this question and you don't need regular dialysis anymore, or 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.

2. 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 HMO Blue? ❑ Yes ❑ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ______________________ ID # for this coverage: ______________________ Group # for this coverage: ______________________

3. Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance, workers compensation, or VA benefits? ❑ Yes ❑ No

What kind of coverage? ______________________ Name of your insurance company: ______________________

4. 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 & Address of Institution: ______________________

Phone Number of Institution: ______________________

5. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

If yes, please provide your Medicaid Number: ______________________

6. Do you or your spouse work? ❑ Yes ❑ No

Please choose the name of a Primary Care Provider (PCP):

Please list your PCP's ID number: ______________________ Are you a current patient? ❑ Yes ❑ No

Please Read and Sign Below:

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

Medicare HMO Blue 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 or 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. I may leave this plan or make changes only at certain times of the year, or under certain special circumstances, by sending a request to Medicare HMO Blue or by calling **1-800-MEDICARE.** TTY users should call **1-877-486-2048.**

Medicare HMO Blue serves a specific service area. If I move out of the area that Medicare HMO Blue 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 Medicare HMO Blue, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Medicare HMO Blue 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 beneficiaries 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 Medicare HMO Blue coverage begins, I must get all of my health care from Medicare HMO Blue, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Medicare HMO Blue and other services contained in my Medicare HMO Blue Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE HMO BLUE WILL PAY FOR THE SERVICES.**

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 health care operations. I also acknowledge that my Medicare HMO Blue plan 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.

Your Signature: Today's Date:

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

Name: ______________________________

Address: ______________________________

Phone Number: (_____) _____ - ________ Relationship to Enrollee: ______________________________

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