Enrollment request for Hope College 51623-601 <BCBSM ID #>

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please contact <Medicare Plus Blue Group PPO> if you need information in another language or format.

Please provide the following information. Please print.

☐ Mr. ☐ Ms. ☐ Mrs.	First name	Middle initial	Last name

Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number

Permanent residence street address (*cannot be a post office box*)	City	State

ZIP code	County	Email address (optional)

Mailing address (*if different from your permanent residence address*)

Street address	City	State	ZIP code

Optional information

Emergency contact name	
Relationship to you	Telephone number

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.

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-NEW. 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 page 4 to send your completed form to the plan.

H9572_Grp21MAPDEnrlFmInt_C FVNR0920
OMB No. 0938-1378
Expires: 07/31/2023

DN 17584 SEP 20

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): ____________ If no, name of retiree: ____________	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependent under this employer or union plan? If yes, name of spouse: ____________ Name(s) of dependent(s): ____________	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance, workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide: Company name: ____________ Name of other drug plan: ____________ ID # for coverage: ____________	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: ____________ Facility street address: ____________ City: ____________ State: ________ ZIP code: ________ Phone number: ____________	☐ **Yes** ☐ **No**
5. Please enter the name of your primary doctor: ____________	**Primary doctor's telephone:**

This enrollment application is part of your <Medicare Plus Blue Group PPO> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

Please contact Blue Cross Medicare Advantage Processing at <**1-800-284-6994**> (TTY users call **711**) if you need information in an accessible format or language other than what is listed below.

Select one if you want us to send you information in a language other than English.
[£ Spanish £ Other]

Select one if you want us to send you information in an accessible format.
☐ Large print £ Audio CD

Customer Service hours are 8:00 a.m. to 5 p.m., Eastern time, Monday through Friday. You can also visit us at **www.BCBSMgroupmedicareplan.com**.

Important: Please read and sign below.

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

<Medicare Plus Blue Group PPO> 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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, or under certain special circumstances. As a Medicare Advantage PPO member, <Medicare Plus Blue Group PPO> works differently than a Medicare supplemental plan. <Medicare Plus Blue Group PPO> pays instead of Medicare, and I will be responsible for the amounts that <Medicare Plus Blue Group PPO> does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in <Medicare Plus Blue Group PPO>.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will or my out-of-pocket costs may be greater. Out-of-Network/non-contracted providers are under no obligation to treat <Medicare Plus Blue Group PPO> members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

<Medicare Plus Blue Group PPO> serves a specific service area. If I move out of the area that <Medicare Plus Blue Group PPO> 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 Plus Blue Group PPO>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverag*e document from <Medicare Plus Blue Group PPO> when I receive it to know which rules I must follow in order to receive 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.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with <Medicare Plus Blue Group PPO>, he/she may be paid based on my enrollment in <Medicare Plus Blue Group PPO>.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the <Medicare Plus Blue 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 <Medicare Plus Blue Group PPO> who will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 Group PPO> or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flyer.			
Signature:			Today's date:
If you are the authorized representative, you must sign above and provide the following information:			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

Blue Cross Medicare Advantage Processing
P.O. Box 3340
Southfield, Michigan 48037-9982

OR

Fax to: 248-603-3553

To enroll by phone and ask questions about our Medicare Advantage plans, call toll-free at 1-800-284-6994 Monday through Friday, 8:00 a.m. to 5:00 p.m., Eastern time. TTY users should call 711.

To review our plans and enroll online, go to www.BCBSMgroupmedicareplan.com.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.