Blue Cross of Idaho | Care Plus

Medicare Advantage Election Form

Already a Blue Cross of Idaho Care Plus Medicare member? Please check the box below:

☐ I have a Blue Cross of Idaho Care Plus Medicare Advantage plan and want to change to a different Blue Cross of Idaho Care Plus Medicare Advantage plan.

Please provide your information:

Last Name	First Name	Middle Initial

Birth Date (mm/dd/yyyy)	Gender: ☐ Male ☐ Female	Phone ( )	Alternate Phone ( )

Email Address (optional)	County

Race (Optional): ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Ethnicity (Optional): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Permanent Residence Street Address (PO Box not allowed)	City	State	Zip Code

Mailing Address (only if different from above)	City	State	Zip Code

Please provide your Medicare insurance information:

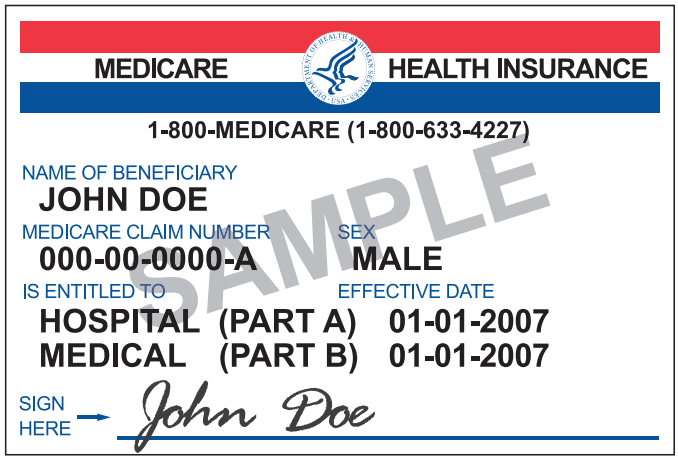
Please take out your Medicare card to complete this section. **You must have Medicare Part A and Part B** to join a Medicare Advantage plan. Please fill in the blanks so they match your red, white and blue Medicare card.

Name of Beneficiary: _____

Medicare Claim Number: _____

Hospital Part A Effective Date: _____

Medical Part B Effective Date: _____


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JOHN DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
MALE

IS ENTITLED TO
HOSPITAL (PART A) 01-01-2007
MEDICAL (PART B) 01-01-2007

EFFECTIVE DATE

SIGN HERE → John Doe

SAMPLE

After completing the election form and providing your signature on Page 4, return it to your agent/broker, or mail to: Blue Cross of Idaho, P.O. Box 8406, Boise, ID 83707-2406. You may also enroll online at ***http://www.bcidaho.com/medicare.***

Please confirm your eligibility for an enrollment period:

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 during the annual enrollment period (October 15 – December 7).
- ☐ 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. I moved 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)_____.
- ☐ I'm 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 recently left a PACE 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 (insert date)_____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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)_____.
- ☐ None of these statements applies to me. I feel a recent change in my situation allows me an exception to enroll. My reason and date it occurred is: _____

Select the plan you want to enroll in for 2016:

Our service area includes the following counties in Idaho: Adams, Bear Lake, Benewah, Blaine, Butte, Camas, Caribou, Clearwater, Custer, Elmore, Gooding, Idaho, Jefferson, Latah, Lewis, Lincoln, Oneida, Shoshone, Teton, Valley, and Washington.

- ☐ True Blue Freedom II (HMO) – **$302.50**
- ☐ True Blue (HMO) without Drug Coverage – **$30.00**
- ☐ Secure Blue (PPO) without Drug Coverage – **$42.00**

Is your Employer Group providing this coverage? ☐ Yes ☐ No

Name of Employer: _____

True Blue HMO plans only: Please choose a primary care physician from the True Blue HMO provider network.
Please visit ***http://www.bcidaho.com/FindAProvider*** for a list of participating network providers.

Name of Primary Care Physician (PCP): _____

Are you an existing patient? ☐ Yes ☐ No PCP ID Number: _____

Optional Supplemental Dental Coverage:

Healthy Smiles Plus includes waiting periods. Basic dental services have a six month waiting period. Preventive and diagnostic dental services do not have a waiting period. Healthy Smiles Plus is available for an additional **$29.90** per month.

☐ Please add Healthy Smiles Plus to my Medicare Advantage coverage.
Are you currently enrolled in a Blue Cross of Idaho dental plan? ☐ Yes ☐ No
If yes, do you want to keep your current dental plan? ☐ Yes ☐ No
If yes, Blue Cross of Idaho ID Number: _____ Name of Dental Plan: _____

Please select a premium payment option:

If you don't select an option below, we will keep your current billing option in place, or send you a monthly bill.

☐ **Automatic Deduction From Your Bank Account**
Please attach a voided check (not a deposit slip). Your signature is required. We automatically deduct your payment on the 5th of each month, unless you choose a different date.

Account Holder Name _____

Bank Name and Address: (city and state)_____

Account Number_____ Routing Number: _____

Account Holder Signature(s) _____

Day of the month (from the 1st and the 24th) you would like your payment to draft _____

☐ **PERSI**: We will contact PERSI for permission to access your funds.
You are responsible for paying your premium until we notify you of your start date.

I am a State of Idaho/Statewide Schools: ☐ Retiree ☐ Requesting payment from my spouse who is a PERSI retiree
Retiree Name_____ Retiree Social Security Number _____

Statewide School District Number _____

☐ **Automatic Deduction from monthly Social Security or Railroad Retirement Board (RRB) benefit check.**
The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. **You are responsible for paying your premium until we notify you of your start date.** In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point that withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **Monthly Bill**

☐ **Employer Group**

Please read and answer these important questions:

1. 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 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. Do you have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs?

   If yes, coverage start date:_____ Coverage end date:_____

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

   Will you have other prescription drug coverage in addition to True Blue HMO or Secure Blue PPO? ☐ 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

4. Do you currently have other health insurance coverage with Blue Cross of Idaho? ☐ Yes ☐ No

   Will this policy continue? ☐ Yes ☐ No

   _____ _____ _____

   Blue Cross of Idaho coverage | Blue Cross ID number | Blue Cross group number

   Please contact Customer Service if you wish to end your other Blue Cross of Idaho health coverage.

5. 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: _____

6. Are you enrolled in the State Medicaid program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number _____

Please read this important information:

If you currently have health coverage from an employer or union, joining a Medicare Advantage plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join True Blue HMO or Secure Blue PPO. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read all sections of this document before signing:

Signature: _____ **Today's Date:** _____

Relationship to beneficiary: ☐ Self ☐ Authorized Representative ☐ Other _____

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

Name:_____ Relationship to Enrollee: _____

Address: _____ Phone Number: _____

For office or agent use only:

Name of agent/broker (if assisted in enrollment): _____ Broker ID: _____

Plan ID Number: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format

☐ Preferred Language: _____

☐ Other formats (like audio or large print)

Please contact Customer Service at 1-888-494-2583 if you need information in another format than what is listed above. TTY users should call 1-800-377-1363. Our office hours are 8 a.m. to 8 p.m., seven days a week.

Release of your information:

By joining this Medicare health plan, I acknowledge that Blue Cross of Idaho will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross of Idaho 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 form. 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 Blue Cross of Idaho or from Medicare.

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

True Blue HMO and Secure Blue PPO are Medicare Advantage plans that have contracts with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only 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. I understand that if I don't 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 when an enrollment period is available (Example: October 15 to December 7 of every year), or under certain special circumstances.

True Blue HMO and Secure Blue PPO serve specific service areas. If I move out of the area that my plan 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 True Blue HMO or Secure Blue 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 Blue Cross of Idaho 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.

I understand that beginning on the date my True Blue HMO coverage begins, I must get all of my health care from True Blue HMO, except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date my Secure Blue PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Secure Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Blue Cross of Idaho and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR BLUE CROSS OF IDAHO 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 Blue Cross of Idaho, he/she may be paid based on my enrollment in True Blue HMO or Secure Blue PPO.

Important information about paying your plan premium:

You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe by mail, or automatic deduction from your bank account. You can also choose to pay your premium by automatic deduction from your PERSI, Social Security or Railroad Retirement Board (RRB) benefit check each month. (If you are enrolling in Employer Group coverage, please select the Employer Group option.)

If you are assessed a Part D Income-Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Blue Cross of Idaho the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. 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***.

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.

Mail a copy of this form to Blue Cross of Idaho, P.O. Box 8406, Boise, ID 83707-2406.
Or enroll online at ***http://www.bcidaho.com/medicare.***
We are available at 1-888-494-2583 from 8 a.m. to 8 p.m., seven days a week.
The hearing impaired can call TTY 1-800-377-1363.

Blue Cross of Idaho Care Plus is a PPO, HMO, or HMO-POS health plan with a Medicare contract. Enrollment in Blue Cross of Idaho Care Plus depends on contract renewal. You must continue to pay your Part B premium. Medicare Advantage plans are offered by Blue Cross of Idaho Care Plus, Inc. When this document says Blue Cross of Idaho, it means Blue Cross of Idaho is providing services for Blue Cross of Idaho Care Plus, Inc. plans.

Y0010_OP16020 Approved 07/01/2015 Form No. 16-592 (09-15)