2024 Excellus BlueCross BlueShield Medicare PPO Individual Enrollment Request Form

Excellus BlueCross BlueShield is a PPO plan with a Medicare contract.
Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

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INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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 and Section 3. 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:

Excellus BlueCross BlueShield

Attn: Enrollment Operations

PO Box 31790

Rochester, NY 14603-1790

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

HOW DO I GET HELP WITH THIS FORM?

Call Excellus BlueCross BlueShield at 1-800-659-1986. TTY users can call 1-800-662-1220.

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

En español: Llame a Excellus BlueCross BlueShield al 1-800-659-1986/TTY 1-800-662-1220 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará 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.

For Internal Use

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

Select the plan you want to join:

☐ Medicare BluePlus (PPO) $109.40 per month ☐ Medicare BlueSalute (PPO) $0 per month

FIRST NAME: **LAST NAME:** **MIDDLE INITIAL:**

BIRTH DATE (MM/DD/YYYY): **SEX:** ☐ MALE ☐ FEMALE **PHONE NUMBER:** ( )

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):

STREET ADDRESS: **CITY:** **STATE:** **ZIP CODE:**

Your Medicare Information:

MEDICARE NUMBER:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Excellus BlueCross BlueShield ? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

IMPORTANT: Read and Sign on the Next Page:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Excellus BlueCross BlueShield.
- By joining this Medicare Advantage Plan, I acknowledge that Excellus BlueCross BlueShield 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).
- If you currently have a Medicare Supplement policy in place, you will need to submit a written request to your carrier to disenroll from that coverage.

IMPORTANT: Read and Sign Below:

- I understand that when my Excellus BlueCross BlueShield coverage begins, I must get all of my medical and prescription drug benefits from Excellus BlueCross BlueShield. Benefits and services provided by Excellus BlueCross BlueShield and contained in my Excellus BlueCross BlueShield "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Excellus BlueCross BlueShield 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 in this section 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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

Contact us if you would prefer us to send you information in a language other than English, or in an accessible format.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

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

List your Primary Care Physician (PCP):

Email Address:

Section 3 - Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" 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.**

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. DON'T pay Excellus BlueCross BlueShield the Part D-IRMAA.

If you will be receiving any form of premium assistance due to Low Income Subsidy or EPIC, you must continue to pay the amount on your monthly bill. Your bill will reflect the lower premium once the notification has been received and applied to your account.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ **Get a bill each month.**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a VOIDED check or provide the following:

ACCOUNT HOLDER NAME:

BANK ROUTING NUMBER:

BANK ACCOUNT NUMBER:

ACCOUNT TYPE:

☐ CHECKING

☐ SAVINGS

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from:

☐ Social Security

☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction**. Any plan premiums due prior to the Social Security or RRB withhold start date will not be deducted from your check; therefore, you are still responsible for any outstanding premiums owed prior to the point 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.)

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 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.

Send completed application to:
Excellus BlueCross BlueShield Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603-1790

Office Use Only:		Plan ID#:	
Effective Date of Coverage:			
ICEP / IEP:	OEPI:	AEP / MA OEP:	SEP (type):
Name of staff member/agent/broker (if assisted in enrollment):			Not Eligible:
Agent/Broker Signature:		**NPN: #**	**Date Received:**

Attestation of 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 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 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 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 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Excellus BlueCross BlueShield at 1-800-659-1986 (TTY users should call 1-800-662-1220) to see if you are eligible to enroll. We are open Monday - Friday, 8:00 a.m. - 8:00 p.m. From October 1 - March 31, 8:00 a.m. - 8:00 p.m., 7 days a week.

Discrimination is Against the Law

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Our Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact our dedicated Medicare Customer Care representatives at 1-877-883-9577, (TTY: 1-800-662-1220). Monday - Friday, 8 a.m. - 8 p.m.
From October 1 - March 31, 8 a.m. - 8 p.m., 7 days a week.

If you believe that our Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone Number: 1-800-614-6575 (TTY: 1-800-662-1220)
Fax Number: 315-671-6656

You can file a grievance in person, or by mail or fax. If you need help filing a grievance, our Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-883-9577 (TTY: 1-800-662-1220). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-883-9577 (TTY: 1-800-662-1220). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如您需要此翻译服务，请致电 1-877-883-9577 (TTY: 1-800-662-1220)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-883-9577 (TTY: 1-800-662-1220)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-883-9577 (TTY: 1-800-662-1220). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-883-9577 (TTY: 1-800-662-1220). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-883-9577 (TTY: 1-800-662-1220) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-883-9577 (TTY: 1-800-662-1220). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-883-9577 (TTY: 1-800-662-1220)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-883-9577 (TTY: 1-800-662-1220). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-883-9577 (TTY: 1-800-662-1220). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-883-9577 (TTY: 1-800-662-1220)पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-883-9577 (TTY: 1-800-662-1220). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-883-9577 (TTY: 1-800-662-1220). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-883-9577 (TTY: 1-800-662-1220). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-883-9577 (TTY: 1-800-662-1220). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-883-9577 (TTY: 1-800-662-1220)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires that a Sales Agent use this form to document the scope of a marketing appointment before the face-to-face sales meeting to ensure your appointment is for the type of plan(s) you're interested in. A separate form should be completed for each person at the meeting. These scopes are required for telephonic and virtual visits too. All information is confidential. **Please initial the box(es) below beside the plan(s) you want the agent to discuss with you.**

☐ Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only go to doctors or hospitals in the plan's network (except in emergencies or specific urgent care situations).

Medicare Preferred Provider Organization (PPO) Plan — Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost* (except in emergencies or specific urgent care situations).

Medicare Dual Eligible Special Needs Plan (D-SNP) — A Medicare Advantage Plan for people who have both Medicare and New York State Medicaid. The plan provides all Original Medicare Part A and Part B health coverage, Part D prescription drug coverage and some Medicaid coverage. You can only go to doctors or hospitals in the plan's network (except in emergencies or specific urgent care situations).

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) -- A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost plans, some Medicare Private Fee-for-Service plans, and Medicare Medical Savings Account plans.

By signing this form, you agree to meet with a Sales Agent to discuss the products checked above. The Sales Agent is either employed or contracted by a Medicare plan and may be compensated based on your enrollment in a plan. This individual does not work directly for the Federal Government.

Signing this form does NOT affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: **Signature Date:**

If you are the authorized representative, please sign above and print below:

Representative's Name:

Your Relationship to the Beneficiary:

To be completed by Sales Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Plan(s) represented during this meeting:	
Agent, if the form was signed by the beneficiary at the time of appointment, provide an explanation why SOA was not documented prior to meeting:	
Agent's Signature:	Date appointment was completed:

*For PPO Plans: Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Customer Care number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-659-1986 (TTY: 1-800-662-1220).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-659-1986 (TTY: 1-800-662-1220)。

Excellus BlueCross BlueShield • 333 Butternut Drive, Syracuse, NY 13214

ExcellusMedicare.com

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