MEDICARE ADVANTAGE

2019

Enrollment Application

Freedom (HMO-POS)
Senior Blue (HMO)
Forever Blue (PPO)
Optional Supplemental Dental

If you have any questions, we're here to help!

bsneny.com/medicare

1-877-258-7453
(TTY 711)

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 8 p.m., Monday – Friday**

BlueShield of Northeastern New York

A division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association.

BlueShield of Northestern New York is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal.

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Please contact BlueShield of Northestern New York if you need information in another language or format (Braille).

To Enroll in Freedom HMO-POS, Senior Blue HMO, or Forever Blue PPO, Please Provide the Following Information:

Please check which plan you want to enroll in:

- ☐ **Freedom Value (HMO-POS)** $0 monthly premium
- ☐ **Freedom Plus (HMO-POS)** $55 monthly premium
- ☐ **Freedom Premier (HMO-POS)** $110 monthly premium
- ☐ **Senior Blue 652 (HMO)** $137 monthly premium
- ☐ **Forever Blue 770 (PPO)** $197 monthly premium

☐ **Optional Supplemental Dental Basic** $19 additional monthly premium with any plan listed here

☐ **Optional Supplemental Dental Enhanced** $38 additional monthly premium with any plan listed here

Last Name **First Name** **Middle Initial** ☐Mr. ☐Mrs. ☐Ms.

Birth Date M M / D D / Y Y Y Y

Sex ☐ M ☐ F

Home Phone Number ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City **State** **ZIP Code**

Mailing Address (only if different from your Permanent Residence Address):

Street Address

City **State** **ZIP Code**

Emergency Contact

Phone Number **Relationship to You**

Email Address

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:

Hospital (Part A) Effective Date _____/ _____/ _____

Medical (Part B) Effective Date _____/ _____/ _____

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

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.

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, quarterly, biannually, or annually. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 BlueShield of Northeastern New York 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% 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 **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.

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

Please select a premium payment option:

☐ Get a bill: ☐ Monthly ☐ Quarterly ☐ Biannually ☐ Annually (annual billing only offered in January)

☐ 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. 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 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.)

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 any more, ***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 Freedom HMO-POS, Senior Blue HMO, or Forever 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**

3 **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 and Phone Number of Institution (number and street)

Important Questions continued

4 **Are you enrolled in your State Medicaid program?**

If "yes," please provide your Medicaid number: ☐ **Yes** ☐ **No**

5 **Do you or does your spouse work?** ☐ **Yes** ☐ **No**

Please list the name of a Primary Care Doctor

Please check one of the boxes below if you would prefer we send you information in a language other than English or in an accessible format (like Braille, audio tape, or large print):

☐ **Language (call for availability)** ☐ **Accessible formats (call for availability)**

Please contact BlueShield of Northeastern New York at 1-877-258-7453 if you need information in an accessible format or language other than what is listed above. TTY users should call 711. Our office hours are:

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STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining Freedom HMO-POS, Senior Blue HMO, or Forever Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Freedom HMO-POS, Senior Blue HMO, or Forever 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 and Sign the Next Page

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

BlueShield of Northeastern New York 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 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 – December 7 of every year), or under certain special circumstances.

Agreement continued

BlueShield of Northeastern New York serves a specific service area. If I move out of the area that BlueShield of Northeastern New York 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 BlueShield of Northeastern New York, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueShield of Northeastern New York 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.

For Senior Blue HMO and Freedom HMO-POS plans: I understand that beginning on the date Senior Blue HMO or Freedom HMO-POS coverage begins, I must get all of my health care from BlueShield of Northeastern New York, except for emergency or urgently needed services or out-of-area dialysis services. *For Forever Blue PPO plans:* I understand that beginning on the date Forever 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, BlueShield of Northeastern New York provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by BlueShield of Northeastern New York and other services contained in my Freedom HMO-POS, Senior Blue HMO, or Forever Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BLUESHIELD OF NORTHEASTERN NEW YORK 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 BlueShield of Northeastern New York, he/she may be paid based on my enrollment in Freedom HMO-POS, Senior Blue HMO, or Forever Blue PPO.

Release of information:

By joining this Medicare health plan, I acknowledge that BlueShield of Northeastern New York will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that BlueShield of Northeastern New York 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 from Medicare.

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

Office Use Only

Name of Staff Member/Agent/Broker (if assisted in enrollment):_____

Plan ID # _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP:_____SEP (type): _____ Not Eligible _____

Broker/Agent Name :_____ ID # _____

Agency_____

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). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a Programs of All-Inclusive Care for the Elderly (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 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 BlueShield at 1-877-258-7453 (TTY 711) to see if you are eligible to enroll.

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Notice of Nondiscrimination

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

BlueShield of Northeastern New York provides:

- No-cost 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)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact the Director, Corporate Compliance and Privacy Officer.

If you believe that BlueShield of Northeastern New York 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:

Director, Corporate Compliance and Privacy Officer, 257 West Genesee Street, Buffalo, NY 14202, 1-800-798-1453, (716) 887-6056 (fax), **complaint.compliance@bsneny.com**. You can file a grievance in person or by mail, fax, or email. 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

Notice of Nondiscrimination

For assistance in English, call customer service at the number listed on your ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کرین۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

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BlueShield
of Northeastern New York