BCN Advantage HMO-POS℠

Medicare and more

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

2011 INDIVIDUAL ENROLLMENT FORM
Medical and Prescription Drug Coverage (Coverage Effective 2011)

Office Use Only:

Please contact BCN Advantage at **1-877-4MyBLUE (1-877-469-2583), TTY users should call 1-800-481-8704,** *if you need information in another format or to be referred to our foreign language line. Call center hours are 8 a.m. to 8 p.m., seven days a week.*

Sec. I To Enroll in BCN Advantage HMO-POS, Please Provide the Following Information:

Check which option you want to enroll in. Please refer to the Rate Premium chart when completing this section.

Region (see Rate Premium chart)	Option 1	Basic	Option 2	Option 3
Region 1	☐ $10	☐ $0	☐ $59	☐ $194
Region 2	☐ $8	☐ $0	☐ $69	☐ $207
Region 3	☐ $24	☐ $0	☐ $69	☐ $193
Region 4	☐ $28	☐ $0	☐ $64	☐ $227
Region 5	☐ $24	☐ $0	☐ $89	☐ $181

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

Birth Date | Sex ☐ Male ☐ Female | Home Phone Number | Alternate Phone Number

E-mail Address | Permanent Residence Street Address (No P.O. Box)

City | State | Zip Code | County

Mailing Address (Only if different from your permanent residence street address)

Street Address ______________________________

City ______________________ State ________ Zip Code ________

OPTIONAL INFORMATION

Emergency Contact Name ______________________________

Relationship to You ________________ Phone Number ________________

Sec. II 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.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ______________________________

Medicare Claim Number Sex ☐ M ☐ F

____

Is Entitled To: Effective Date

HOSPITAL (Part A) ________________

MEDICAL (Part B) ________________

Sec. III Please Read the Following Statement Sections and Check the Box that Applies to You.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 (for 2010 enrollment for the calendar year 2011. Annual enrollment period for calendar year 2012 is October 15 - December 7). 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 the information is incorrect, you may be disenrolled.

- ☐ 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:____________).
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I live in a long-term care facility (for example, a nursing home or rehabilitation hospital).
- ☐ I recently left Programs of All-inclusive Care for the Elderly (PACE®) (insert date:____________).
- ☐ 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 involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date:____________).
- ☐ I am leaving/losing employer or union coverage on (insert date: ____________).
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ 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 get Extra Help paying for Medicare prescription drug coverage, but do not have Medicaid.
- ☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date:____________).
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan (effective date:____________).
- ☐ I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.
- ☐ I had Medicare prior to now, but am now turning 65.
- ☐ None of these statements apply to me.*

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Sec. IV 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 "Electronic Funds Transfer (EFT)," an automatic withdrawal from your bank account. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 co-insurance. 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.

Sec. IV Continued — Paying Your Plan Premium

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 monthly bill. Please select a premium payment option:

☐ Electronic funds transfer (EFT) from your bank account each month. Please allow three to four weeks for processing your application. You may receive a premium bill during the time your application is being processed so please pay the bill. Future monthly premiums will be automatically withdrawn from your specified account on the fifth day of every month.

Please enclose a **VOIDED** check or provide the following:

Account Holder Name: ______________________________

Bank Routing Number: ______________________________
(first set of numbers located on left side of check)

Bank Account Number: ______________________________
(second set of numbers located in the center of check)

Account Type: ☐ Checking ☐ Savings

☐ Get a bill on a monthly basis.

☐ Automatic deduction from my monthly Social Security benefit check. *This option is not available if your monthly plan premium is $200 or more.* (The Social Security deduction may take two months or more to begin. BCN Advantage will bill me monthly until Social Security withholding begins. The first deduction from your Social Security benefit check will include all premiums due from the Social Security deduction effective date).

Sec. V — Please Read and Answer These Important Questions

1. 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 BCN Advantage? ☐ 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:

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If you answered "yes," please provide the following information:

Name of Institution			
Address			
City	State	Zip Code	Telephone

3. 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, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

   Note: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Blue Cross Blue Shield of Michigan organization as a commercial member or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998.

Sec. V Continued — Please Read and Answer These Following Important Questions

4. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

   If "yes," please provide your Medicaid number: ____________________

5. Do you or your spouse work? ☐ Yes ☐ No
6. Please choose a Primary Care Physician (PCP), clinic or health center:

   Not all Blue Care Network providers are contracted with BCN Advantage. Please verify that your PCP is contracted with BCN Advantage.

Last Name	First Name	City

Are you a current patient of this physician/clinic/health center? ☐ Yes ☐ No

7. In what format would you prefer to receive your provider directory?

   ☐ Paper ☐ Email ☐ CD

   If email, please print your email address: ____________________

   Please contact BCN Advantage at **1-877-4MyBLUE (1-877-469-2583), TTY users should call 1-800-481-8704,** *if you need information in another format or to be referred to our foreign language line. Call center hours are 8 a.m. to 8 p.m., seven days a week.*

Please Read This Important Information

If you currently have health coverage from an employer or union, joining BCN Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCN Advantage. 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 Below

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

BCN Advantage HMO-POS is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and Part 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31), or under certain special circumstances by sending a request to BCN Advantage or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048. Medicare is available seven days a week, 24 hours a day.

BCN Advantage serves a specific area. If I move out-of-the area that BCN Advantage 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 BCN Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document (also known as a member contract or subscriber agreement) from BCN Advantage 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 usually aren't covered under Medicare while out-of-the-country except for limited coverage near the U.S. border.

I understand that beginning on the date BCN Advantage coverage begins, I must get all of my health care from BCN Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCN Advantage and other services contained in my BCN Advantage Evidence of Coverage document will be covered. **Without authorization, NEITHER MEDICARE NOR BCN ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that if I get assistance from a sales agent, broker or other individual employed by or contracted with BCN Advantage, he/she may be paid based on my enrollment in BCN Advantage.

Release of Information:

By joining this Medicare health plan, I acknowledge that BCN Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BCN Advantage 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 content 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 BCN Advantage or Medicare.

Signature	Today's Date

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

Name			Phone Number
Address	**City**	**State**	**Zip Code**
Relationship to Enrollee			

AGENT/OFFICE USE ONLY (Applicants do not complete this section)

Note to Producing Agents: 2011 paper enrollment forms must be keyed into bcbsm.com/agent/or submitted to the Managing or General Agent within 24 hours of accepting the paper enrollment form.

Date Producing Agent accepted paper enrollment from Medicare Eligible: ☐☐/☐☐/☐☐☐☐

Date Managing or General Agent or Association received paper enrollment form from Producing Agent: ☐☐/☐☐/☐☐☐☐

Name of Managing/General Agent or Association: ____________________

Name of Producing Agent *(print first/last names)*: ____________ ____________
First Name Last Name

Signature of Producing Agent: ____________________

Email of Producing Agent: ____________________

2-digit Managing or General Agent or Association Code: ☐☐ 5-digit Producing Agent Code: ☐☐☐☐☐

I assisted the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of Person entering enrollment information online *(print first/last names)*: ____________ ____________
First Name Last Name

BCBSM Source Code: ☐ BCBSM Badge # : E☐☐☐☐☐☐

Please note: Not all BCN providers are contracted with BCN Advantage. Please verify that the primary care physician listed in this form is contracted with BCN Advantage by calling 1-877-4MyBLUE (1-877-469-2583), TTY users should call 1-800-481-8704.

Be sure to have the member complete *Sections III and V in their entirety.*

Return this form to:

BCN Advantage
Mail Code C411
P.O. Box 5184
Southfield, MI 48086-9719