



Medicare and more

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

INSTRUCTIONS FOR BCN ADVANTAGE HMO-POS ENROLLMENT APPLICATION

It's easy to enroll in BCN Advantage:

To enroll online, go to:

- BCN Advantage's website at MiBCN.com/medicare, **or**
- The Centers for Medicare and Medicaid Services Online Enrollment Center at www.medicare.gov/find-a-plan.

To enroll using this form:

- Complete a separate form for each person enrolling. If you need another copy, make a photocopy or call us.
- Find the region in which you live from the chart on the next page, and check the box for the plan that you want on the form.
- When you've completed the form, keep the yellow copy for your records. **Don't send payment with this application.** Return the completed form in the postage-paid envelope, or mail it to:

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

Tips for completing your application:

- Use a black or blue ink pen.
- Print your answers, except where your signature is required.
- Choose an emergency contact who is aware of your medical history.
- Complete every section.
- Check only one plan option.
- Copy the information from your Medicare card directly onto the picture of the card on the form.
- Sign the form.

For more information or questions, call **1-877-4MyBLUE (1-877-469-2583)**, TTY users should call **1-800-481-8704**. Call center hours are 8 a.m. to 8 p.m., seven days a week. An independent agent licensed to sell the Blues can also assist you with your plan choice and application. Call us at the number above if you would like help locating a Blues agent.

What happens next?

We'll call to make sure that you understand how this plan works and confirm your intent to enroll. If we're not able to reach you by telephone, we will send a letter that contains similar information. Once CMS approves your application, we'll send you a confirmation of enrollment letter. This usually happens within 30 days. We'll bill you based on your plan choice and your premium payment option. To introduce you to your new plan, you'll receive an information packet about your benefits and the extras you receive with your Blues coverage.

BCN Advantage HMO-POSSM Premium Table

Monthly premiums vary. To determine your premium:

1. Locate the county in which you permanently live.
2. Determine your monthly premium based on the plan of your choice.
3. Check only one option box on the application.

Region	Monthly Premium for Elements	Monthly Premium for Basic	Monthly Premium for Classic	Monthly Premium for Prestige
Region 1: Allegan, Kent, Muskegon, Newaygo, Oceana, Ottawa, Van Buren	\$15	\$0	\$60	\$213
Region 2: Barry, Clinton, Eaton, Gratiot, Ingham, Ionia, Kalamazoo, Midland	\$13	\$0	\$71	\$226
Region 3: Calhoun, Jackson, Livingston, Monroe, Montcalm, Washtenaw	\$29	\$0	\$83	\$212
Region 4: Bay, Genesee, Lapeer, Saginaw, Shiawassee, Tuscola	\$33	\$0	\$78	\$246
Region 5: Macomb, Oakland, St. Clair, Wayne	\$29	\$0	\$103	\$200



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**2012 INDIVIDUAL ENROLLMENT FORM
Medical and Prescription Drug Coverage
(Coverage Effective 2012)**

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)	Elements	Basic	Classic	Prestige
Region 1	<input type="checkbox"/> \$15	<input type="checkbox"/> \$0	<input type="checkbox"/> \$60	<input type="checkbox"/> \$213
Region 2	<input type="checkbox"/> \$13	<input type="checkbox"/> \$0	<input type="checkbox"/> \$71	<input type="checkbox"/> \$226
Region 3	<input type="checkbox"/> \$29	<input type="checkbox"/> \$0	<input type="checkbox"/> \$83	<input type="checkbox"/> \$212
Region 4	<input type="checkbox"/> \$33	<input type="checkbox"/> \$0	<input type="checkbox"/> \$78	<input type="checkbox"/> \$246
Region 5	<input type="checkbox"/> \$29	<input type="checkbox"/> \$0	<input type="checkbox"/> \$103	<input type="checkbox"/> \$200

Mr. Mrs. Ms. First Name _____ Middle Initial _____ Last Name _____

Birth Date (/ /) Sex Male Female Daytime Phone Number ()

Permanent Residence Street Address (No P.O. Box) _____ City _____ State _____

Zip Code _____ County _____ E-mail Address _____

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: **HOSPITAL (Part A)** _____ Effective Date _____

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 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 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 (insert date: ___/___/___).
- 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: ___/___/___).
- In the last 12 months, I left a Medigap policy to join a Medicare Advantage plan* for the first time (*Medicare Advantage plan with prescription drug coverage) (insert date: ___/___/___).
- In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
- 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 disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
- I was enrolled in a Special Needs Plan (SNP) but I have the lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date: ___/___/___).
- I had Medicare prior to now, but am now turning 65.
- None of these statements apply to me.*

*Please contact BCN Advantage at **1-877-4MyBLUE (1-877-469-2583)**, TTY users should call **1-800-481-8704**, to see if you are eligible to enroll. Call center hours are 8 a.m. to 8 p.m., seven days a week.

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 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 the RRB. DO NOT pay BCNA HMO-POS the Part D-IRMAA.

If your premium is over \$200, we encourage you to enroll in our Electronic Funds Transfer (EFT) for automatic deductions or write a check each month. Consider automatic deductions if you do not wish to receive a statement 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 or Railroad Retirement Board (RRB) benefit check. *This option is not available if your monthly plan premium is \$200 or more. (The Social Security/RRB deduction may take two months or more 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 or if your automatic deduction will begin on a date later than your enrollment effective date, we will send you a paper bill for your monthly premiums owed.)*

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
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3. 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.

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.

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

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 October 15 – December 7 of every year), or under certain special circumstances.

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 from 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