

# Medicare PLUS Blue PPO<sup>SM</sup>



Blue Cross  
Blue Shield  
of Michigan

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

## INSTRUCTIONS FOR MEDICARE PLUS BLUE PPO ENROLLMENT APPLICATION

### ***It's easy to enroll in Medicare Plus Blue PPO:***

To enroll online, go to:

- [www.bcbsm.com/medicare/ppo.shtml](http://www.bcbsm.com/medicare/ppo.shtml) **or**
- The Centers for Medicare and Medicaid Services Online Enrollment Center at [www.medicare.gov/find-a-plan](http://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:

Medicare Plus Blue PPO  
P.O. Box 3817  
Southfield, MI 48037-3817

### ***Tips for completing your application:***

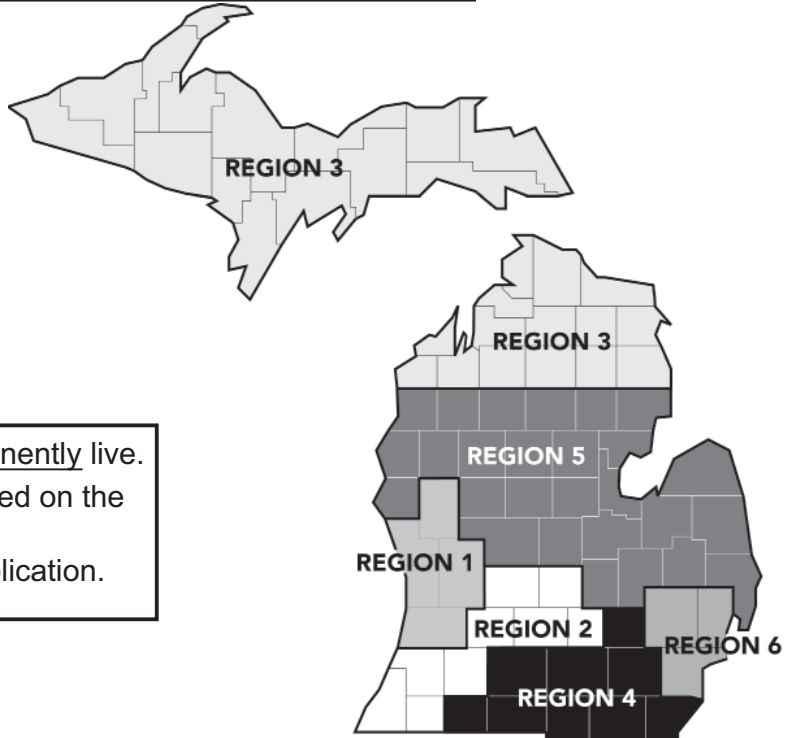
- Use a black or blue ink pen.
- Print your answers, except where your signature is required.
- Choose an emergency contact who is aware of your medical history.
- Complete every section.
- Check only one plan option.
- Copy the information from your Medicare card directly onto the picture of the card on the form.
- Sign the form.
- Mail it promptly. We are not permitted to accept an enrollment application that is dated more than 30 days before we receive it.

For more information or questions, call **1-877-4MY-BLUE (1-877-469-2583)**. TTY users should call **1-800-481-8704**. 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 (or automatically deduct your premium if you choose that 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.

## Medicare Plus Blue PPO<sup>SM</sup> 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	Vitality <sup>SM</sup> Plan Monthly Premium	Signature <sup>SM</sup> Plan Monthly Premium	Assure <sup>SM</sup> Plan Monthly Premium
<b>Region 1/Southwest Michigan:</b> Allegan, Kent, Muskegon, Newaygo, Ottawa	\$38	\$83	\$139
<b>Region 2/Mid-Michigan:</b> Barry, Berrien, Cass, Clinton, Eaton, Ingham, Ionia, Kalamazoo, Van Buren	\$43	\$118	\$172
<b>Region 3/Upper Michigan:</b> Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iron, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Marquette, Menominee, Montmorency, Ontonagon, Oscoda, Otsego, Presque Isle, Schoolcraft	\$78	\$128	\$231
<b>Region 4/South Michigan:</b> Branch, Calhoun, Hillsdale, Jackson, Lenawee, Livingston, Monroe, St. Joseph, Washtenaw	\$63	\$143	\$204
<b>Region 5/Northeast Michigan:</b> Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Iosco, Isabella, Lake, Lapeer, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Oceana, Ogemaw, Osceola, Roscommon, Saginaw, St. Clair, Sanilac, Shiawassee, Tuscola, Wexford	\$73	\$163	\$238
<b>Region 6/Southeast Michigan:</b> Macomb, Oakland, Wayne	\$78	\$118	\$222

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

Office Use Only:

Please contact Medicare Plus Blue PPO at 1-877-4My-BLUE (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 a Medicare Plus Blue PPO Plan, Please Provide the Following Information:

Check which option you want to enroll in. Please refer to the Rate Premium chart when completing this section.  I would like my preferred effective date to be (Effective date: \_\_/\_\_/\_\_).

Region (see Rate Premium chart)	Vitality	Signature	Assure
Region 1/Southwest Michigan	<input type="checkbox"/> \$38	<input type="checkbox"/> \$83	<input type="checkbox"/> \$139
Region 2/Mid-Michigan	<input type="checkbox"/> \$43	<input type="checkbox"/> \$118	<input type="checkbox"/> \$172
Region 3/Upper Michigan	<input type="checkbox"/> \$78	<input type="checkbox"/> \$128	<input type="checkbox"/> \$231
Region 4/South Michigan	<input type="checkbox"/> \$63	<input type="checkbox"/> \$143	<input type="checkbox"/> \$204
Region 5/Northeast Michigan	<input type="checkbox"/> \$73	<input type="checkbox"/> \$163	<input type="checkbox"/> \$238
Region 6/Southeast Michigan	<input type="checkbox"/> \$78	<input type="checkbox"/> \$118	<input type="checkbox"/> \$222

Mr.  Mrs.  Ms. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Birth Date ( / / ) Sex  Male  Female Daytime Phone Number ( ) Alternate Phone Number ( )  
(MM/DD/YYYY)

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

Zip Code \_\_\_\_\_ County \_\_\_\_\_ E-mail Address (Optional) \_\_\_\_\_

#### 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 <input type="checkbox"/> M <input type="checkbox"/> F	
Is Entitled To:		Effective Date	
<b>HOSPITAL (Part A)</b>		_____	
<b>MEDICAL (Part B)</b>		_____	

**Sec. III Please Read the Following Statements 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 that this 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 a PACE<sup>®</sup> program on (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 am being disenrolled from a Medicare special needs plan because I no longer have special needs status.
- 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: \_\_/\_\_/\_\_).

\*Please contact Medicare Plus Blue PPO at **1-877-4MY-BLUE (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 may owe) by mail, "Electronic Funds Transfer (EFT)" or 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, 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 Medicare Plus Blue PPO 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 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](http://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.

**If you don't select a payment option, you will get a bill each month. You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check to \$200. If you select a Medicare Plus Blue plan with a monthly premium over \$200, the premium cannot be taken out of your Social Security check. Instead, you must pay your premium directly to us. We encourage you to enroll in our (EFT) so you do not have to receive a monthly statement or write a check. Consider automatic deductions if you do not wish to receive a statement each month.**

**Please select a premium payment option:**

- Electronic funds transfer 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:

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 each month.

- Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check. (The Social Security/Railroad Retirement Board (RRB) deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Sec. V**

**Please Read and Answer These Important Questions**

1. Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other medical or prescription drug coverage in addition to Medicare Plus 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: \_\_\_\_\_

2. 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

City

State

Zip Code

Telephone

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

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**If you currently have health coverage from an employer or union, joining Medicare Plus Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Medicare Plus 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.

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

Medicare Plus Blue PPO 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. 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.

Medicare Plus Blue PPO serves a specific area. If I move out of the area that Medicare Plus Blue PPO 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 Medicare Plus 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 Medicare Plus Blue PPO 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 Medicare Plus 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, Medicare Plus Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Medicare Plus Blue PPO and other services contained in my Medicare Plus Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR MEDICARE PLUS BLUE PPO 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 Medicare Plus Blue PPO, he/she may be paid based on my enrollment in Medicare Plus Blue PPO.

**Release of Information:**

By joining this Medicare health plan, I acknowledge that Medicare Plus Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medicare Plus Blue PPO 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: 2012 paper enrollment forms must be keyed into [bcbsm.com/agent](http://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**