

# Prescription Blue PDP<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 PRESCRIPTION BLUE PDP ENROLLMENT APPLICATION

### ***It's easy to enroll in Prescription Blue PDP:***

To enroll online, go to:

- [www.bcbsm.com/medicare/pdp.shtml](http://www.bcbsm.com/medicare/pdp.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.
- 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:

Prescription Blue PDP  
P.O. Box 3667  
Southfield, MI 48037-3667

### ***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**. 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 (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.

# Prescription Blue PDP<sup>SM</sup>



**Blue Cross  
Blue Shield**  
of Michigan

## 2011 INDIVIDUAL ENROLLMENT FORM Prescription Drug Coverage (Coverage Effective 2011)

Office Use Only:

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

Please contact Prescription Blue PDP 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 Prescription Blue PDP, Please Provide the Following Information:

Please check the plan you want to enroll in:

- Option A \$72.00 per month       Option B \$88.00 per month

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First Name	Middle Initial	Last Name
Birth Date ( / / ) (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number ( )	Alternate Phone Number ( )	
E-mail Address		Permanent Residence Street Address (No P.O. Box)		
City	State	Zip Code	County	
<b>Mailing Address</b> (Only if different from your permanent residence street address)				
Street Address _____				
City _____ State _____ Zip Code _____				
<b>OPTIONAL INFORMATION</b>				
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 or Part B to join a Medicare prescription drug plan.

<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>	
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 Prescription Drug Plan only during the annual enrollment period between October 15 and December 7 of each year. Note: The 2011 Annual Enrollment Period is between November 15 and December 31. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the annual enrollment 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 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 U.S. 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 recently lost Medicare Part B but I still have Part A.
- I had Medicare prior to now, but am now turning 65.
- None of these statements apply to me.\*

\*Please contact Prescription Blue PDP 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 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 benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a 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.**

**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:

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 center of check)*

Account Type:  Checking  Savings

- Get a bill each month.

- Automatic deduction from my monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

**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 Prescription Blue PDP?  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 of Institution

City	State	Zip Code	Telephone of Institution
------	-------	----------	--------------------------

*Please contact Prescription Blue PDP 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. VI

**Please Read This Important Information**

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Prescription Blue PDP, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

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

Prescription Blue PDP is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Prescription Blue PDP of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Prescription Blue PDP will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 - December 7), unless I qualify for certain special circumstances.

Prescription Blue PDP serves a specific service area. If I move out of the area that Prescription Blue PDP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Prescription Blue PDP network pharmacies. Once I am a member of Prescription Blue PDP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Prescription Blue PDP when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Prescription Blue PDP, he/she may be paid based on my enrollment in Prescription Blue PDP. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

**Release of Information:**

By joining this Medicare prescription drug plan, I acknowledge that Prescription Blue PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Prescription Blue PDP 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 this plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law 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 by Prescription Blue PDP or by 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](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**