Blue Cross Group Medicare Advantage℠

Proposed Effective Date:
__ __ / 0 1 / 2 0 __ __
(Must be after enrollee signature date)

Blue Cross Group Medicare Advantage Plan Retiree Enrollment Form

To enroll in Blue Cross Group Medicare Advantage, please provide the following information:

Please check the plan you want to enroll in:	Please check the name of your pension fund:
☐ Plan 1: $443.61 Per Member Per Month ☐ Plan 2: $206.00 Per Member Per Month ☐ Plan 3: $0 Per Member Per Month	☐ Laborers & Retirement Board Employees (LABF) ☐ Municipal Employees (MEABF) ☐ Policemen (PABF) ☐ Firemen (FABF)

Employer: City of Chicago	Group #: PIL00006
Legal LAST Name: Legal FIRST Name: Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: __ __ / __ __ / __ __ __ __	Sex: ☐ M ☐ F	Employee ID:

Home Phone Number: ( ) –	Alternate Phone Number: ( ) –

Permanent Residence Street Address (don't enter a PO Box unless you're experiencing homelessness):

City:	County:	State:	ZIP Code:

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

Street Address:	City:	State:	ZIP Code:

Emergency Contact Name:

Phone Number: ( ) –	Relationship to You:

Member 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.

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

Name (as it appears on your Medicare Card):

Medicare Number:

Some boxes may be blank.

is Entitled to:	Effective Date:
HOSPITAL (Part A)	
MEDICAL (Part B)	

Applicant LAST name: FIRST name:

All fields for the next four questions are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin.
- ☐ **I choose not to answer**.

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one:

☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term _____

☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual ☐ I use a different term _____
☐ I don't know ☐ **I choose not to answer.**

Please read and answer these important questions:

1. Are you the retiree? ☐ Yes ☐ No

If **yes**, retirement date: ____ ____ / ____ ____ / ____ ____ ____ ____

If **no**, name of retiree: _____

2. Will you have other prescription drug coverage (like VA, TRICARE, other private insurance, federal employee health benefits coverage, or state pharmaceutical assistance programs) in addition to Blue Cross Medicare Advantage? ☐ Yes ☐ No

If **yes**, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	Member number for this coverage:	Group number 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 & Phone Number of Institution (number and street):

_____

Applicant LAST name: FIRST name:

Please read and answer these important questions (Continued):

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

If yes, please provide your Medicaid number: _____

Please provide the name of a Primary Care Physician (PCP), clinic or health center:

PCP First Name:	PCP Last Name:	PCP ID#:

Select one if you want us to send you information in a language other than English.

☐ **Spanish**

Select one if you want us to send you information in an accessible format.

☐ **Braille** ☐ **Large Print** ☐ **Audio CD** ☐ **Data CD**

Call Blue Cross Group Medicare Advantage at 1-877-299-1008 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through Sept. 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. TTY users can call 711.

Please Read and Sign Below

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

Blue Cross Group Medicare Advantage 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. 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 at any time or make changes only at certain times of the year if an enrollment period is available, (Example: October 15 – December 7 of every year), or under certain special circumstances.

Blue Cross Group Medicare Advantage has a service area that includes the United States and its territories. If I move out of the area that Blue Cross Group Medicare Advantage serves, I need to notify my Employer Group Benefits Office so I can disenroll and find a new plan in my new area. Once I am a member of Blue Cross Group Medicare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Blue Cross Group Medicare 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 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 Blue Cross Group Medicare Advantage coverage begins, I must get all of my health care from Blue Cross Group Medicare Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Cross Group Medicare Advantage and other services contained in my Blue Cross Group Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR Blue Cross Group Medicare Advantage WILL PAY FOR THE SERVICES.**

Applicant LAST name:	FIRST name:

Please Read and Sign Below (Continued)

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber's Employer Group and Blue Cross and Blue Shield of Illinois, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Cross and Blue Shield of Illinois to use the Blue Cross and/or Blue Shield Service Marks in the State of Illinois, and that Blue Cross and Blue Shield of Illinois is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Illinois and that no person, entity, or organization other than Blue Cross and Blue Shield of Illinois shall be held accountable or liable to Subscriber for any of Blue Cross and Blue Shield of Illinois' obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Illinois other than those obligations created under other provisions of this agreement.

Release of Information:

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

Applicant LAST name:	FIRST name:

For individuals helping enrollee with completing this form only:

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, authorized representatives, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee:

☐ Agent ☐ Broker ☐ SHIP Counselor ☐ Authorized Representative ☐ Other (third party) ☐ Self

Signature: _____ National Producer Number (Agents/Brokers only): _____

Office Use Only:

Plan ID #:			
☐ ICEP / IEP	☐ AEP	☐ SEP (type):	☐ Not Eligible
Name of staff member/agent/broker (if assisted in enrollment):			
LC:		Referral ID:	
Subgroup ID #:		Subgroup Description:	
Class ID #:		Plan ID #:	
Plan Description:			

MAIL APPLICATIONS TO:
Blue Cross Group Medicare Advantage℠
C/O Medicare Advantage Prescription Drug (MAPD) Forms
PO Box 4555
Scranton, PA 18505
FAX APPLICATIONS TO: (855) 895-4747

PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.