

2010 Individual Enrollment Form for Medicare Prescription Drug Plan

Please contact BCBSNC if you need information in another language or format (Braille).



For Plan Office Use Only	
Member #	J _____
Effective Date	_____
Group #	_____
<input type="checkbox"/> AEP	<input type="checkbox"/> IEP <input type="checkbox"/> Not Eligible
<input type="checkbox"/> SEP (type)	_____

A. Personal Information (Please PRINT your name **exactly** as it appears on your Medicare card.)

First Name	Middle Initial	Last Name	Jr., Sr.

Birth Date (MM/DD/YYYY)	Gender (Choose One)	Phone	
____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	____ - ____ - ____	
Residence Street Address (No PO Boxes)			

City	State	Zip	
_____	____	____ - ____ - ____	
County	Alternate Phone Number (Optional)		
_____	____ - ____ - ____		
Mailing Address (If different from residence, PO Box allowed)			

City	State	Zip	
_____	____	____ - ____ - ____	
Emergency Contact Name (Optional)			

Relationship To You	Phone		
_____	____ - ____ - ____		

B. Select Your Plan Benefit Package

Blue Medicare Rx

Enhanced..... \$ 81.20 per month

Standard..... \$ 56.80 per month

D. Select Your Payment Option


You can pay your monthly plan premium by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security 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% of 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. Generally you must stay with the payment option you choose for the rest of the year. If you don't select a payment option, you will get a bill each month.

Get a bill each month. (Additional payment options are listed on the bill that you get each month.)

Automatic deduction from your 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.)

C. Medicare Information

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.

	
Medicare Claim Number	
Is Entitled To:	Effective Date (MM/DD/YY)
Hospital (Part A):	____/____/____
Medical (Part B):	____/____/____

You **must** have Medicare Parts A and/or B to join a Medicare Prescription drug plan.

E. Please Read and Answer This Important Question

Yes No 1. Some individuals may have other drug coverage, including other private health insurance (includes retiree benefits), North Carolina State Health Plan, TRICARE, Federal Employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Blue Medicare Rx that will continue after enrollment? If "yes," you will be sent an Other Health Insurance survey to complete and mail back to us.

F. Eligibility to Enroll (Please Check One)

- I am enrolling during the Annual Enrollment Period (AEP) Nov. 15 through Dec. 31
- I am new to Medicare or just turning 65 and am enrolling during my Initial Enrollment Period (IEP)
- I am enrolling during a Special Enrollment Period (SEP). Select reason:
 - 1. I recently moved outside the service area for my current plan on ____ / ____ / ____ (MM/DD/YYYY)
 - 2. I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
 - 3. I get extra help paying for Medicare prescription drug coverage.
 - 4. I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped getting extra help on ____ / ____ / ____ (MM/DD/YYYY)
 - 5. I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility) on ____ / ____ / ____ (MM/DD/YYYY)
 - 6. I recently left a PACE program on ____ / ____ / ____ (MM/DD/YYYY)
 - 7. I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's) on ____ / ____ / ____ (MM/DD/YYYY)
 - 8. I am leaving employer or union coverage on ____ / ____ / ____ (MM/DD/YYYY)
 - 9. I belong to a pharmacy assistance program provided by my state.
 - 10. I recently returned to the United States after living permanently outside of the U.S on ____ / ____ / ____ (MM/DD/YYYY)
 - 11. None of these statements applies to me.* Other SEP reason: _____

*Please contact BCBSNC at 1-888-247-4142 to see if you are eligible to enroll. We are open 8 a.m. - 8 p.m., 7 days a week. TTY users should call 1-888-247-4145.

G. Applicant Agreement

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of North Carolina) on this application means that I have read and understand the contents of this application and the Statements of Understanding and Release of Information on the back of this page.

(MM/DD/YYYY)

Your Signature _____ Today's Date: ____ / ____ / ____

If signed by an authorized individual (as defined 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 Blue Medicare Rx or by Medicare. Please attach documentation with this application.

Name _____ Signature _____
Address _____
City _____ State _____ Zip _____
Phone _____ - _____ - _____ Relationship to Beneficiary _____

LICENSED AGENT USE ONLY

Agents must submit a signed enrollment form within 24 hours of receipt.

Agent's Signature _____ Date App Received _____

Print Agent's Name _____ Telephone Number _____

Agent Number _____

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Blue Medicare Rx, 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 Blue Medicare Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Medicare Rx. 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.

Statement of Understanding

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

1. Blue Medicare Rx 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 Blue Medicare Rx of any prescription drug coverage that I have or may get in the future.
2. 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 Blue Medicare Rx will end that enrollment.
3. 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 (November 15 - December 31), unless I qualify for certain special circumstances.
4. I understand that Blue Medicare Rx serves North Carolina residents. If I move permanently to another state, I need to notify the plan so I can disenroll and find a new plan in my new service area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Blue Medicare Rx network pharmacies.
5. Once I am a member of Blue Medicare Rx, I have the right to appeal plan decisions about payment or services if I disagree.
6. I will read the Evidence of Coverage document from Blue Medicare Rx when I get it to know which rules I must follow to get coverage.
7. 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.
8. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Medicare Rx, he/she may be paid based on my enrollment in Blue Medicare Rx.
9. 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

1. By joining this Medicare prescription drug plan, I acknowledge that Blue Medicare Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
2. I also acknowledge that Blue Medicare Rx 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.
3. 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.