

Effective date of coverage (to be filled in by Medicare Blue Choice): \_\_\_\_\_

**To Enroll in Medicare Blue Choice, Please Provide the Following Information:**

<p><b>Individual - Please check which plan you want to enroll in:</b></p> <p><input type="checkbox"/> Medicare Blue Choice Value \$10 per month</p> <p><input type="checkbox"/> Medicare Blue Choice Platinum \$25 per month</p> <p><input type="checkbox"/> Medicare Blue Choice Optimum \$65 per month</p>	<p><b>Employer Group – Please complete the following:</b></p> <p>Employer Name _____ Group #: _____</p> <p>Are you the Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, retirement date (month/date/year): _____</p> <p>If no, name of retiree: _____</p> <p>Are you covering a spouse or dependents under this employer plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, name of spouse: _____</p> <p>Name of dependents: _____</p>
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LAST Name: _____	FIRST Name: _____	MI: _____	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (____/____/____) (M M/DD/Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (providing this information is optional): _____	Home Phone Number: (____) _____

Permanent Residence Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Mailing Address** (Only if different from your Permanent Residence Address):  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact (Optional field):** \_\_\_\_\_  
**Phone Number (Optional field):** \_\_\_\_\_ **Relationship to You (Optional field):** \_\_\_\_\_

**E-Mail Address (Optional field):** \_\_\_\_\_

**Please Provide Your Medicare Insurance Information:**

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> <li>• Please fill in these blanks so they match your red, white and blue Medicare card - OR -</li> <li>• Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage Plan.</p>	<p><b>MEDICARE HEALTH INSURANCE</b></p> <p>Name: _____</p> <p>Medicare Claim Number Sex _____</p> <p>_____ - _____ - _____</p> <p>Entitled to Effective Date</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>
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**Your Plan Premium Option:**

You can have the monthly premium for this plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check?**  Yes  No

**Please Read and Answer These Important Questions:**

- Do you have End Stage Renal Disease (ESRD)?  Yes  No  
If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.
- 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 Medicare Blue Choice?  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: \_\_\_\_\_

**Please Read and Answer These Important Questions:**

- 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): \_\_\_\_\_
- Are you enrolled in your State Medicaid program?  Yes  No  
If yes, please provide your Medicaid number: \_\_\_\_\_
- Do you or your spouse work?  Yes  No

**Primary Care Physician Information:**  
Please enter the name of your primary care physician and OB/GYN from the Medicare Blue Choice Provider Directory.  
Physician Name: \_\_\_\_\_ OB/GYN Physician Name: \_\_\_\_\_  
Are you currently a patient?  Yes  No

**If You Are Choosing Medicare Blue Choice Optium For Your Plan, Please Read This Important Information!**

**If you currently have health coverage from an employer or union, joining Medicare Blue Choice Optimum could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Medicare Blue Choice Optimum may change how your current coverage works. 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 is no 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:**

Medicare Blue Choice is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Medicare Blue Choice or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Medicare Blue Choice serves a specific service area. If I move out of the area that Medicare Blue Choice 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 Blue Choice, 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 Blue Choice when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date my Medicare Blue Choice coverage begins, I must get all of my health care from Medicare Blue Choice, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by Medicare Blue Choice and other services contained in my Medicare Blue Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE BLUE CHOICE WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) 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 Medicare Blue Choice or by Medicare.

**Your Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

If you are the authorized representative, you must provide the following information:

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Relationship to Enrollee:** \_\_\_\_\_

**For Office Use Only:**

Group # \_\_\_\_\_ Subgroup # \_\_\_\_\_ Ck Digit \_\_\_\_\_ Member ID # \_\_\_\_\_  
Effective Date of Coverage \_\_\_\_\_ Pkg \_\_\_\_\_  
Election Period: IEP \_\_\_\_\_ AEP \_\_\_\_\_ SEP (type) \_\_\_\_\_  
Plan Representative Signature: \_\_\_\_\_

# Medicare Blue Choice Enrollment Application



Medicare Blue Choice  
P.O. Box 40246  
Rochester, NY 14604  
1-800-659-1986  
TDD 1-800-421-1220