Thank You For Choosing
Employer Group Medicare Advantage

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Employer Group Medicare Advantage Enrollment Request Form

Please contact Blue Cross & Blue Shield of Rhode Island (BCBSRI) if you need information in another language or alternate format (large print*).

Section 1 - Please Provide Personal Information (Please Print)

Employer Name or Plan Sponsor	Effective Date** _____/_____/_____ MM / DD / YYYY
Medicare Subgroup #: MCA	

Last Name	First Name	Middle Initial

Birth Date _____/_____/_____ MM / DD / YYYY	Sex ☐ M ☐ F
Home Phone Number ( )	Cell Phone Number ( )

Permanent Residence Street Address (P.O. Box is not allowed)

City	State	ZIP Code

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

City	State	ZIP Code

Email Address

Section 2 - Please Provide the Name of Your Primary Care Provider (PCP)

Last Name	First Name
Address	

City	State	ZIP Code

Are you now seeing or have you recently seen this provider?	☐ Yes	☐ No	Phone ( )

Section 3 - 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.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

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

*Not all materials may be available in alternate formats.

**The effective date of enrollment will be the first of the month following the signature date, unless a future date is requested.

Section 4 - Please Read and Answer These Important Questions

1. Are you the retiree? ☐ Yes ☐ No
   If yes, provide your retirement date (MM/DD/YYYY) _____
   If no, provide name of retiree:_____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If "yes", name of spouse:_____
   Name of dependents: _____
   Please note: If you are covering a spouse and/or dependent, they will need to submit a separate enrollment request form.

3. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to BlueCHiP for Medicare or HealthMate Coast-to-Coast for Medicare? ☐ 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:_____

4. 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: _____
   Phone number of institution: _____

5. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

   We're asking for this **optional** information to help us better understand our members' needs. Your responses or choice not to respond will not affect your benefits, coverage, or costs.

6. We try to accommodate a member's preferred language to receive BCBSRI correspondence when possible. Do you have a preferred language other than English?

   ☐ Spanish
   ☐ Portuguese

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

   ☐ Large Print
   ☐ Braille
   ☐ Audio CD
   ☐ Data CD

8. Would you like to receive the following materials electronically as they become available?
   ☐ Plan material e.g. Medical Explanation of Benefits, Annual Notice of Change, Premium Invoice

   Email Address:_____
   Cell phone (text communications only):_____

Section 5 – Read and Sign Below

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

BCBSRI contracts with the Federal government to offer two Medicare Advantage plans, BlueCHiP for Medicare and HealthMate for Medicare (each, individually, a "plan"). 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Once I am a member of the plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the plan 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.

To obtain in-network coverage, I understand that beginning on the date my plan coverage begins, all services except for emergency or urgently needed services or out-of-area dialysis services must be obtained from providers participating in the network specific to the plan I have chosen. Services authorized by the plan and other services contained in my Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN 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 the plan, he/she may be paid based on my enrollment in the plan.

BCBSRI serves a specific service area. If I move out of the area that BCBSRI serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that the plan will release my information including my prescription drug event data to Medicare, which may release it for research and other purposes that 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.

Enrollee Signature: X _____ **Today's Date:** _____

If you're the authorized representative, sign above and complete fields below:	
Last Name	First Name
Address	
Relationship to Enrollee	Phone Number ( )

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

<table>
<tr><th colspan="4">Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form</th></tr>
<tr><td colspan="3">Signature (if assisted in enrollment)</td><td>Agent Received Date</td></tr>
<tr><td colspan="2">Print Name</td><td>Broker ID#</td><td>Broker/Agent National Producer Number (NPN)</td></tr>
<tr><td colspan="3">Effective Date of Coverage _____/_____/_____
MM / DD / YYYY</td><td>Relationship to Enrollee</td></tr>
<tr><td colspan="4">☐ AEP ☐ ICEP ☐ OEP
☐ SEP ☐ IEP ☐ OEPI (Institutionalized)</td></tr>
</table>

Blue Cross Blue Shield of Rhode Island

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Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.