

## 2013 Enrollment Request Form Blue Shield of California Medicare Rx Plan (PDP) Employer Group/Union Prescription Drug Benefit Plan

This form is for Medicare-eligible retirees who want to enroll in the Blue Shield of California Medicare Rx Plan (PDP), a Group Prescription Drug Benefit plan.

**To enroll, please fill in all the information requested below. Read the terms and conditions on page 3, and then sign and date.**

Employer group or union name \_\_\_\_\_ Group or union No. \_\_\_\_\_  
(leave blank if not provided by your employer group or union)

Last name		First name		Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (____/____/____) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ( )	Alternate phone number ( )		

**Permanent residence (no P.O. boxes)**

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

**Mailing address (only if different from your permanent residence address)**

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Emergency contact (optional)	Relationship to you (optional)	Phone number (optional) ( )
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E-mail address (optional) \_\_\_\_\_

- I am willing to receive required plan materials via e-mail (i.e., enrollment notifications the Annual Notice of Change and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.

You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

**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 and Part B to join a Medicare Advantage plan.**

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MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_ Sex \_\_\_\_\_

Is Entitled To **HOSPITAL (Part A)** \_\_\_\_\_ Effective Date \_\_\_\_\_

**MEDICAL (Part B)** \_\_\_\_\_

**Please read and answer these important questions**

1. Are you the retiree?  Yes  No

If yes, retirement date (month/date/year) \_\_\_\_\_

If no, name of retiree \_\_\_\_\_

2. Are you covering a spouse or dependent(s) under this employer group or union plan?

Yes  No

If yes, name of spouse\* \_\_\_\_\_

Name of dependent(s) \_\_\_\_\_

\* Please ensure both you, your spouse, and dependent(s) each complete and return an enrollment form.

3. Do you or your spouse work?  Yes  No

4. Are you enrolled in your State Medicaid (Medi-Cal) program?  Yes  No

If yes, please provide your Medicaid (Medi-Cal) number \_\_\_\_\_

5. 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 the Blue Shield of California Medicare Rx Plan?  Yes  No

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

Name of other coverage \_\_\_\_\_

ID No. for this coverage \_\_\_\_\_

Group No. for this coverage \_\_\_\_\_

6. 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 and phone number of institution (number and street) \_\_\_\_\_

Phone number of institution (       ) \_\_\_\_\_

Please contact Blue Shield of California Medicare Rx Plan at **(888) 239-6469** [TTY **(888) 239-6482**], 7 a.m. to 8 p.m., seven days a week, if you need information in another format or language.



## 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 the Blue Shield of California Medicare Rx Plan, 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.

## Please read and sign below

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

Blue Shield of California Medicare Rx Plan 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 Shield of California Medicare Rx Plan 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 any time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Shield of California Medicare Rx Plan 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 (for example, during my group's open enrollment period or the Annual Enrollment Period, October 15 – December 7), unless I qualify for certain special circumstances.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan 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 Blue Shield of California Medicare Rx Plan network pharmacies. Once I am a member of the Blue Shield of California Medicare Rx 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 Blue Shield of California Medicare Rx Plan 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.

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 Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx Plan 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.

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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 Medicare.

\_\_\_\_\_  
Enrollee signature

\_\_\_\_\_  
Today's date

**If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information**

Name	Address
Phone number (    )	Relationship to enrollee

**RETURN FORM TO:**

San Bernardino County  
Employee Benefits and Services Division (EBSB)  
157 West Fifth Street, First Floor  
San Bernardino, CA 92415-0440

**Medicare Prescription Drug Plan Use Only:**

Plan ID No. \_\_\_\_\_ NIPR# \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_ IEP \_\_\_\_\_ AEP \_\_\_\_\_ SEP (type) \_\_\_\_\_

Plan Representative/Agent/Broker Signature \_\_\_\_\_