Kansas City BLUE MEDICARE ADVANTAGE

Section 1 - All fields on this page are required (unless marked optional)

Employer Sponsor: **Product:** □ HMO □ PPO	**Effective Date:** ____/____/_____

FIRST name:	LAST name:	Middle Initial:

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: □ Male □ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

City:	State:	ZIP Code:

Your Medicare information:

Medicare Number __ __ __ __ – __ __ __ – __ __ __ __

Answer these important questions:

□ Yes □ No	Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Medicare Advantage?	
Name of other coverage:	Member number for this coverage:	Group number for this coverage:

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Medicare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that Blue Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Blue Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Blue Medicare Advantage. Benefits and services provided by Blue Medicare Advantage and contained in my Blue Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered.

- Neither Medicare nor Blue Medicare Advantage will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application.
- If signed by an authorized representative (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.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 - All fields on this page are optional

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

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

□ Spanish □ Vietnamese □ Chinese

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

Please contact Blue Medicare Advantage at 1-866-508-7140 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends and holidays from April 1 through September 30. TTY users can call 711.

Do you work? □ Yes □ No Does your spouse work? □ Yes □ No

List your Primary Care Physician (PCP), clinic, or health center (please also include the PCP ID):

I want to get the following materials via email. Select one or more.

□ Member Handbook □ Premium Invoice □ Newsletter □ Health Risk Assessment

E-mail address:

Paying your plan Premiums

You can pay your monthly plan premium by mail, (including any late enrollment penalty that you currently have or may owe) Electronic Funds Transfer (EFT), credit card, debit card each month.

□ Invoice: Check, Credit or Debit Card □ I pay my Employer/Plan Sponsor
□ Bank Account or EFT

If you have to pay a Part D Income Related Monthly Adjustment Amount (Part D IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Medicare Advantage the Part D-IRMAA.

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 and 1860D-1 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.