Thank you for choosing Group BlueCHiP for Medicare.

Please tear off this card and insert between the pages when completing this enrollment form. Thank you.

unique form ID

BlueCHiP for Medicare
2017 Employer Group Enrollment Request Form

Blue Cross Blue Shield of Rhode Island

Please contact BlueCHiP for Medicare if you need information in another language or format (large print).*

To Enroll in a BlueCHiP for Medicare Employer Group Plan, Please Provide the Following Information:

Employer or Union Name:	Group #:

Please check which plan you want to enroll in:

❑ BlueCHiP for Medicare Group Plus (HMO)
❑ BlueCHiP for Medicare Group Preferred (HMO-POS)
❑ BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS)
❑ BlueCHiP for Medicare Group Preferred Unlimited 2 (HMO-POS)

LAST Name:	FIRST Name:	Middle Initial:	❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
(_____ /_____ /_____) MM / DD / YYYY	❑ M ❑ F	(_____) _____–_____	(_____) _____–_____

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

Street Address:	City:	State:	ZIP Code:

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

Street Address:	City:	State:	ZIP Code:

Primary Language:

E-mail Address:

Please Provide Your Medicare Insurance Information:

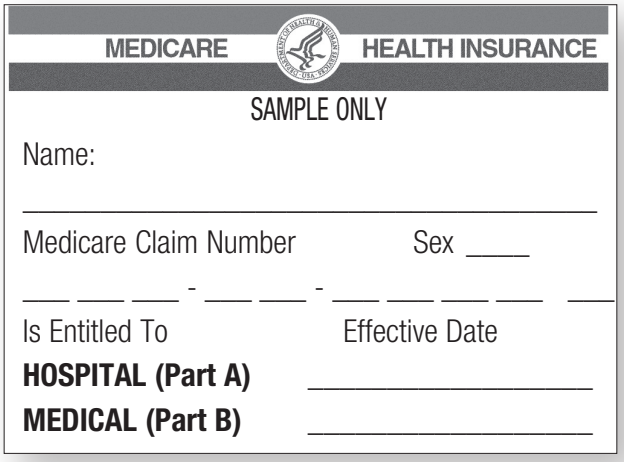
Please take out your Medicare Card to complete this section.

- 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.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

_____

Medicare Claim Number Sex ____

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

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 dependents under this employer or union plan? ❑ Yes ❑ No
   If yes, name of spouse: _____
   Name of dependents: _____

3. Do you or your spouse work? ❑ Yes ❑ No

* Not all materials may be available in alternate formats.

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4. Do you have End Stage Renal Disease (ESRD)? ❑ Yes ❑ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. 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? ❑ Yes ❑ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: _____ ID # for 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: _____ Phone Number: (_____) _____–_____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Please write the name of your Primary Care Physician (PCP):

_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ❑ Spanish ❑ Large print

Questions? Please contact the Medicare Concierge Team at 1-800-267-0439 (TTY users should call 711) seven days a week from October 1 to February 14, 8:00 a.m. to 8:00 p.m. From February 15 to September 30, you can call Monday through Friday from 8:00 a.m. to 8:00 p.m. On Saturday and Sunday, call from 8:00 a.m. to noon. You can use our automated answering system outside of these hours.

Please Read and Sign Below:

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

BlueCHiP for Medicare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in 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. 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. 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 of every year), or under certain special circumstances.

BlueCHiP for Medicare serves a specific service area. If I move out of the area that BlueCHiP for Medicare 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 BlueCHiP for Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueCHiP for Medicare 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.

I understand that beginning on the date BlueCHiP for Medicare coverage begins, I must get all of my healthcare from BlueCHiP for Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BlueCHiP for Medicare and other services contained in my BlueCHiP for Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUECHIP FOR MEDICARE 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 BlueCHiP for Medicare, he/she may be paid based on my enrollment in BlueCHiP for Medicare.

BlueCHiP for Medicare Group Preferred, Group Preferred Unlimited, and Group Preferred Unlimited 2 plan members have the option of receiving covered services outside of the plan's network. Members obtaining services under the Point of Service (POS) benefit are responsible to pay applicable coinsurances and any additional amounts if the provider does not accept Medicare assignment.

Release of Information: By joining this Medicare health plan, I acknowledge that BlueCHIP for Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that BlueCHiP for Medicare 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.

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 by BlueCHiP for Medicare or by Medicare.

Signature:	**Today's Date:**

If you are the enrollee, please ensure you have signed above. If you are signing on behalf of the enrollee, please sign above AND complete the authorized representative section below.

If you are the authorized representative, you must *sign above and* provide the following information:

Last Name:	**First Name:**
Address: City: State: ZIP Code:	
Relationship to Enrollee:	**Phone Number: ( ) -**

Office Use Only

Name of staff member (if assisted in enrollment):	Broker ID#:
Plan ID #:	Effective Date of Coverage:

ICEP/IEP: _____ AEP: _____ SEP (type): ____ Not Eligible:

Please keep yellow copy for your records.

500 Exchange Street • Providence, RI 02903-2699 • www.bcbsri.com/Medicare

Blue Cross Blue Shield of Rhode Island

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