Thank you for choosing Employer Group Medicare Advantage

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 or Plan Sponsor Medicare Subgroup #: MCA_____			Effective Date _____/_____/_____ MM / DD / YYYY
☐ Mr. ☐ Mrs. ☐ Ms.	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	
Primary Language			
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 or employee of the plan sponsor (the "qualifying individual")? ☐ Yes ☐ No
   If you are a retiree of the plan sponsor please provide your retirement date (MM/DD/YYYY) _____
   If you are not the qualifying individual, please provide their name:_____
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. Optional: Select one if you want us to send you information in a language other than English.
   - ☐ Spanish
   - ☐ Portuguese

6. Optional: Select one if you want us to send you information in an accessible format.
   - ☐ Large Print
   - ☐ Braille
   - ☐ Audio CD

7. Optional: What's your race? Select all that apply.

   - ☐ White
   - ☐ Asian Indian
   - ☐ Japanese
   - ☐ Other Asian
   - ☐ Guamanian or Chamorro
   - ☐ Black or African American
   - ☐ Chinese
   - ☐ Korean
   - ☐ Native Hawaiian
   - ☐ Other Pacific Islander
   - ☐ American Indian or Alaska Native
   - ☐ Filipino
   - ☐ Vietnamese
   - ☐ Samoan
   - ☐ Portuguese

   I choose not to answer.

8. Optional: Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

   - ☐ No, not of Hispanic, Latino/a, or Spanish origin
   - ☐ Yes, Puerto Rican
   - ☐ Yes, another Hispanic, Latino, or Spanish origin
   - ☐ Yes, Mexican, Mexican American, Chicano/a
   - ☐ Yes, Cuban

   ☐ I choose not to answer

Section 5 – Please 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: October 15 – December 7 of every year), 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 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 by the plan or from 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 on the following page.

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

Please keep the yellow copy for your own records. Thank you.

Internal Use Only – To Be Completed by Agent

☐ AEP	☐ ICEP	☐ IEP
☐ SEP		☐ OEPI (Institutionalized)
☐ Other SEP (SEP Reason): _____		
Sales Agent Signature (if assisted in enrollment)		Agent Received Date
Print Sales Agent Name		Broker ID#
		Effective Date of Coverage _____/_____/_____. (MM / DD / YYYY)

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Blue Cross Blue Shield of Rhode Island