



Post Office Box 45296
Jacksonville, FL 32232-5296

**EMPLOYER/UNION
GROUP HEALTH PLAN
ENROLLMENT FORM**

To Enroll in BlueMedicare Group PPO, Please Provide the Following Information:

Check desired plan: Plan 1 Plan 2 Plan 3 Other

Full Name of Employer/Union:

Requested effective date:

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

Permanent Residence Street Address:

City:

State:

ZIP Code:

Birth Date:

(__/__/____)
M M D D Y Y Y Y

Sex:

M F

Home Phone Number:

()

Alternate Phone Number:

()

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

Address: City: State: ZIP Code:

Optional Field:

E-mail Address: _____

Please check here if you would like to receive information from us via email.

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.



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. Do you or your spouse work? Yes No

2. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

3. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to BlueMedicare Group PPO?

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: Group # 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 & Phone Number of Institution (number and street):

Please contact BlueMedicare Group PPO at 1-800-926-6565 if you would prefer us to send you information in a format or language other than English. Our office hours are 8 a.m. – 9 p.m. ET, seven days a week. TTY users should call 711.

Please Read and Sign on the Next Page:

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

PLEASE KEEP IN MIND THAT BLUEMEDICARE PPO IS NOT A MEDICARE SUPPLEMENT PLAN. BlueMedicare Group PPO 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, or under certain special circumstances.

BlueMedicare Group PPO serves a specific service area. If I move out of the area that BlueMedicare Group PPO 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 BlueMedicare Group PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueMedicare Group PPO 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. However, once I am a member of BlueMedicare Group PPO, I will have coverage worldwide for emergencies outside the United States.

I understand that beginning on the date BlueMedicare Group PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, BlueMedicare Group PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by BlueMedicare Group PPO and other services contained in my BlueMedicare Group PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **PRIOR AUTHORIZATION IS REQUIRED ONLY FOR CERTAIN SERVICES (REFER TO YOUR EVIDENCE OF COVERAGE).** Without authorization, **NEITHER MEDICARE NOR BLUEMEDICARE GROUP PPO 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 BlueMedicare Group PPO, he/she may be paid based on my enrollment in BlueMedicare Group PPO.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program, and the Medicare Savings Program.

Please Read and Sign Below:

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueMedicare Group PPO 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 BlueMedicare Group PPO or by Medicare.

Signature: _____

Today's Date: _____

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

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee: _____

Office Use Only (If assisted with enrollment):

Name of Agent: _____ Agent ID: _____

Plan ID #: _____ Effective Date of Coverage: _____