blue california

2021 Individual Enrollment Request Form

Blue Shield Rx Plus (PDP) and Blue Shield Rx Enhanced (PDP) Medicare Prescription Drug Plan

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Mail, Fax, or Email your completed and signed form to:

Mail: Blue Shield of California
PO Box 948
Woodland Hills, CA 91365-9856

Fax: (877) 251-3660

Email: WHMembership@blueshieldca.com

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Customer Care at **(888) 239-6469**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Customer Care al **(888) 239-6469** (TTY **711**) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

☐ Blue Shield Rx Plus (PDP) ($59.00 per month)

☐ Blue Shield Rx Enhanced (PDP) ($130.40 per month)

First Name

Middle Initial (optional):

Last Name

Sex ☐ M ☐ F

Birth Date: (MM/DD/YYY)

Phone number

Permanent Residence street address (Don't enter a P.O. Box):

Street Address

City

State

ZIP code

Mailing address, if different from your permanent address (P.O. Box allowed):

Street Address

City

State

ZIP code

Your Medicare information:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Shield Rx Plus (PDP) or Blue Shield Rx Enhanced (PDP)?

☐ Yes ☐ No

Prescription drug coverage

Name of other coverage:

ID # for this coverage:

Group #:

IMPORTANT: Read and sign below:

- I must keep Part A and Part B to stay in my Blue Shield Rx Plus or Blue Shield Rx Enhanced.
- By joining this Medicare Advantage Plan, I acknowledge that my Blue Shield Rx Plus or Blue Shield Rx Enhanced will release my information with Medicare, who may use it to track beneficiary enrollment, for payment, and for other purposes allowed by Federal statutes 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 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:

Street Address:

City | State | ZIP code

Phone Number:

Relationship to Enrollee:

Section 2 – All fields in this section 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

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

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Customer Care at **(888) 239-6469** [TTY users should call **711**] if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30.

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

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

☐ I am willing to receive required plan materials via email (i.e. enrollment notifications and Annual Notice of Changes) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations, and plan newsletter) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Customer Care at the number on your plan ID card.

Email Address

Paying your plan premiums

You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), or credit card each month.

☐ Get a monthly bill.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name:

Bank routing number:

Bank account number:

Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card:

Name of Account holder as it appears on card:

Account number:

Expiration Date:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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 Shield of California the Part D-IRMAA.

Producer information: Producer name and ID or NPN **is required**.

FMO/Agency name: JAMES BARRICKS
(please print appointed agency name)

FMO/Agency ID #: _____
(please print agency tax ID)

Producer name: JAMES BARRICKS
(please print writing agent name)

Producer ID #: 063287258
(please print agent tax ID)

Producer NPN #: 2692016
(please print NPN number)

Producer phone number: 310-678-6315

Producer email address: INSURE@BARRICKSINSURANCE.COM

Date application received by producer: _____

Producer signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is a PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

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.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date).

  _____
- ☐ I recently was released from incarceration. I was released on (insert date).

  _____
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).

  _____
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date).

  _____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).

  _____
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date).

  _____

- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date).

- ☐ I recently left a PACE program on (insert date).

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).

- ☐ I am leaving employer or union coverage on (insert date).

- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date).

- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan. I was disenrolled from the SNP on (insert date).

- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Blue Shield Customer Care at **(888) 239-6469** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30.