BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

2021 Blue MedicareRx[SM] Medicare Prescription Drug Plan (PDP) Individual Enrollment Form

Easy options to enroll:

Enroll online at **YourAZMedicareSolutions.com**

Call Blue MedicareRx Medicare Solutions specialists:
1-833-229-3593 (TTY: **711**), 8 a.m. to 8 p.m., local time

- October 1–March 31: seven days a week
- April 1–September 30: Monday through Friday

Contact your licensed sales representative

Fill out the enrollment form and mail to:
Blue MedicareRx (PDP) Arizona
P.O. Box 3777
Scranton, PA 18505

Questions? Review the Summary of Benefits included in your 2021 Blue MedicareRx Enrollment Kit or call our Medicare Solutions specialists at the phone number above or your licensed sales representative.

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Blue MedicareRx Medicare Prescription Drug Plan Individual Enrollment form

Please contact Blue MedicareRx if you need information in another language or format (Braille).
To enroll in Blue MedicareRx, please provide the following information.

A. Personal information (please print clearly)

Last Name: First Name: Middle Initial:

❑ Mr. ❑ Mrs. ❑ Ms. | ❑ Male ❑ Female | Birth date: M M D D Y Y Y Y

Home Phone Number: ( ) –

Alternate Phone Number (optional): ( ) –

E-mail Address:

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:

B. Enroll me in

Blue MedicareRx: ❑ Value $31.50 ❑ Essential $39.50 ❑ Enhanced $105.50

C. 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 (MMDDYYYY):

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Enrollee name: ________________________________

D. Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or RRB benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Blue MedicareRx.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213**, 7 a.m. to 7 p.m. Monday - Friday. TTY users should call **1-800-325-0778**. You can also apply for Extra Help online at **ssa.gov/prescriptionhelp**. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

❑ Receive a paper bill. **Do not send a premium payment with this application.**

❑ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

Account holder name: ________________________________

Financial institution: ________________________________

Bank routing number: | | | | | | | | | |

Bank account number: | | | | | | | | | | | | | | | | | |

Account type: ❑ Checking ❑ Saving

A The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.

B Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

❑ 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/EFT deduction may take two or more months to begin. In most cases, if the Social Security/RRB accepts your request for automatic deduction, the first deduction from your Social Security/RRB benefit check will include all premiums due from your enrollment effective date up to the point withholdings begin. If Social Security/RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums. If you do not pay your premium for the months before the deduction takes effect, you may be disenrolled from the plan.

Enrollee name: ______________________________

E. Enrollment period determination

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment 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. **Note: A choice of effective dates is only allowed in certain enrollment situations identified below.** In all other cases, or if you do not specify an effective date, your effective date will be the first of the month after your form is received by the plan.

IF THE STATEMENT YOU SELECT REQUIRES A DATE, PLEASE USE THE FOLLOWING FORMAT:

M	M	D	D	Y	Y	Y	Y

❑ I am enrolling during the annual enrollment period, October 15 through December 7, for a January 1, 2021 effective date. (Note: the enrollment application must be received by December 7 for the enrollment to be effective on January 1.)

❑ I am new to Medicare. My Medicare Part A effective date is ☐☐☐☐☐☐☐☐ and my Medicare Part B effective date is ☐☐☐☐☐☐☐☐.

I AM MOVING OR HAVE MOVED

❑ 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 the following date: ☐☐☐☐☐☐☐☐. Requested effective date is ☐☐☐☐☐☐☐☐ (cannot be before your move date).

❑ I 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 the following date: ☐☐☐☐☐☐☐☐.

❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on the following date: ☐☐☐☐☐☐☐☐.

I LOST OR AM LOSING MY COVERAGE

❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) or was notified of the loss (whichever is later). I lost my drug coverage on the following date: ☐☐☐☐☐☐☐☐. Requested effective date is ☐☐☐☐☐☐☐☐.

❑ I am being disenrolled from a special needs plan because my condition does not qualify me for that plan as of the following date: ☐☐☐☐☐☐☐☐.

❑ I am being disenrolled from my existing plan due to its non-renewal as of the following date: ☐☐☐☐☐☐☐☐. (Note: The enrollment period for this is December 8 – February 28. Enrollments received in December, January or February are effective the first of the next month).

Enrollee name: ______________________________

❑ I have been disenrolled from a Medicare Advantage Prescription Drug plan due to loss of Part B but continue to be entitled to Part A as of the following date: ☐☐☐☐☐☐☐☐.

❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

❑ I am leaving employer or union coverage on the following date: ☐☐☐☐☐☐☐☐. Requested effective date is ☐☐☐☐☐☐☐☐.

❑ I am leaving my Medicare Advantage plan within 12 months of my initial enrollment under a special enrollment period to go back to a Medigap (Medicare Supplement) plan as of the following date: ☐☐☐☐☐☐☐☐.

EXTRA HELP

❑ 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 the following 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on the following date: ☐☐☐☐☐☐☐☐.

OTHER REASONS

❑ I recently obtained lawful presence status in the U.S. I got this status on the following date: ☐☐☐☐☐☐☐☐.

❑ 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 the following 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.

❑ I was recently released from incarceration. I was released on the following date: ☐☐☐☐☐☐☐☐.

❑ Other special enrollment period not identified above. ______________________________

If none of these statements applies to you or you're not sure, please contact Blue MedicareRx Medicare Solutions specialists at the number on the front of this form to see if you are eligible to enroll.

Enrollee name: ________________________________

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

❑ Spanish ❑ Other formats (e.g., Braille, audio tape, or large print)

Please contact Blue MedicareRx at the number on the front of this form if you need information in an accessible format or language other than what is listed above.

F. Please answer the following questions to help Medicare coordinate your benefits

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs. Will you have other **prescription** drug coverage in addition to Blue MedicareRx? ❑ Yes ❑ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage:	ID number for this coverage:	Group number for this coverage:
______________________	______________________	______________________

2. 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 the Institution: ________________________________
   Address and Phone Number of Institution (number and street):
   ____

G. Please sign below

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application, including the information in Sections H and I. 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 Medicare.

Signature: ________________________________ **Today's Date:** ______________

❑ I give permission to the licensed agent identified below to enter my enrollment form online through **YourAZMedicareSolutions.com**.

For Authorized Representative use only

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

Name (Print): ________________________ Phone number: (____) ______________

Address: ____________________ City: ______________ State: ________ ZIP Code: __________

Relationship to Enrollee: ________________________________

❑ I want all mail for this member sent to me.

Enrollee name: ________________________________

For Agent use only

Certified Agent/Broker Name (Print): ________________________________

Agent/Broker of Record #: ________________________________

Broker of Record (Print): ________________________________
(Enter the name of the Entity or Person contracted with BCBSAZ.)

❑ Check if you have received this **completed** enrollment form with the enrollee's signature from the enrollee. This paper form must be submitted using one of the methods below within **two (2) calendar days** of the date you receive it. Sign and date below when you receive the form from the beneficiary.

Broker/Agent signature: ________________________________

Date form received: ____________________ Phone number: (   ) ____________________

Check selected submission method and enter information as appropriate:

❑ Paper to online application. Enter online confirmation number:____________________

❑ Application faxed. Enter date faxed (keep fax confirmation sheet):____________________

❑ Application sent overnight. Be sure to keep the overnight receipt.

H. Stop – Please read this important information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Blue MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Blue MedicareRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue MedicareRx. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Enrollee name: ________________________________

I. Enrollment authorization – by completing this enrollment application, I agree to the following

After carefully reading all statements in this section, please sign Section I of this form. Keep the copy marked "Enrollee" for your records.

1. Blue MedicareRx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue MedicareRx will end that enrollment.
2. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15–December 7), unless I qualify for certain special circumstances.
3. Blue MedicareRx serves a specific service area. If I move out of the area that Blue MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue MedicareRx network pharmacies. Once I am a member of Blue MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx when I get it to know which rules I must follow to get coverage.
4. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
5. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Blue Cross Blue Shield of Arizona, he/she may be paid based on my enrollment in Blue MedicareRx.
6. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.
7. **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that Blue MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue MedicareRx will release my information, including my prescription drug event data, to Medicare, who 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.

Enrollee name: ________________________________

An Independent Licensee of the Blue Cross Blue Shield Association

2021 Enrollment Receipt

Please use this as your temporary proof of coverage until Medicare has confirmed your enrollment, and you receive your member ID card. **This receipt is not a guarantee of enrollment.**

This copy is for your records only. Please do not resubmit enrollment.

Fill out this plan recap with your licensed sales representative (if applicable). It will take you through some plan details to help you better understand your new plan.

Here are some details about your new plan:

Enrollee name:

Application date:	My plan coverage begins (effective date):
My new plan name is: ❑ Blue MedicareRx Value ❑ Blue MedicareRx Essential ❑ Blue MedicareRx Enhanced	My plan type is: ☒ PDP

Premium information:

My plan has a: $________ monthly premium. I understand I must remain enrolled in Medicare Part A and/or Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me.

If I owe a late enrollment penalty (LEP), it is not included in my premium and I will need to add it to my premium each month.

I must live in the plan's service area. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.

I can cancel my enrollment in this plan before my coverage starts by calling Member Services at **1-833-229-3593** (TTY users should call **711**) for free. We are open October 1 – March 31, seven days a week, 8 a.m. to 8 p.m., April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m. Once my coverage starts, I may have to wait until the Open Enrollment Period to make a plan change, unless I qualify for a Special Election Period.

Call your licensed sales representative if you have any questions:

Licensed sales representative name and ID number:	Licensed sales representative phone number:

Enrollee name: ________________________________

Do you currently have a Medicare Advantage-Prescription Drug (MAPD) plan? ❑ Yes ❑ No

❑ I understand I am signing up for a Medicare prescription drug plan. I understand I cannot combine a Medicare Advantage-Prescription Drug (MAPD) plan with a stand-alone prescription drug plan (PDP).

Blue Cross® Blue Shield® of Arizona (BCBSAZ) is contracted with Medicare to offer HMO and PPO Medicare Advantage plans and PDP plans. Enrollment in BCBSAZ plans depends on contract renewal. Coverage is available to residents of Arizona.

If you need more information

Visit **YourAZMedicareSolutions.com**

Call Blue MedicareRx Medicare Solutions specialists: **1-833-229-3593** (TTY: **711**), 8 a.m. to 8 p.m., local time

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