

**2009 BlueAdvantage PPOSM
Enrollment Request Form
Sapphire and Diamond Options**

Unfold the enrollment request form and print clearly with a black ball point pen.

- **Press hard enough so that your writing appears on the yellow copy.**
- **Be sure to complete all required fields and answer all questions.**
- **Sign and date the third page of the enrollment form.**
- **Remove the yellow copy and keep it for your records.**
- **Mail the enrollment request form in the envelope provided or to the address below:**

**BlueCross BlueShield of Tennessee
Attention: Medicare Sales
P.O. Box 180205
Chattanooga, TN 37402**

Fax Number: 423-296-4582



A health plan with a Medicare contract.

2009 BlueAdvantage PPO Enrollment Request Form

To enroll in BlueAdvantage PPO, please provide the following information:

LAST Name	FIRST Name	Middle Initial	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> Ms.		
Permanent Residence Street Address		County	City	State	Zip
Mailing Address (If different from permanent residence address)			City	State	Zip
Home Phone Number (____) - _____		Month	Birth Date Day	Year	Social Security Number (providing this information is optional)
Alternate Phone Number: (____) - _____			E-mail Address:		
Emergency Contact (optional)		Phone Number (____) - _____	Relationship to You		

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 the Social Security Administration or 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 check which plan you want to enroll in:

- BlueAdvantage PPO SapphireSM
- BlueAdvantage PPO DiamondSM

Paying Your Premium

If you are enrolling in a plan with a \$0 premium and we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

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 does not cover.

If you don't select a payment option, you will receive a bill each month.

Please Select a Premium Payment Option:

- Receive a bill
- Electronic funds transfer (EFT) from your bank account each month.
Please complete and attach the enclosed authorization form.
- Automatic deduction from your monthly Social Security benefit check.
(The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

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

If you answered “Yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. 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 BlueAdvantage 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:** _____

3. 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): _____

4. Are you enrolled in your State Medicaid program? Yes No

If “Yes,” please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

What is your language of preference? _____

Please check one of the boxes below if you would prefer us to send you information in another format:

Audio Tape

Large Print

Please contact BlueAdvantage PPO at 1-800-841-7434 (TTY users should call TTY: 1-888-423-9490) if you need information in another format than what is listed above.

Our office hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.



Please read this important information and application agreement:

If you currently have health coverage from an employer or union, joining the BlueAdvantage PPO could affect your employer or union health benefits. If you have health coverage from an employer or union, joining **BlueAdvantage PPO** may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

BlueAdvantage PPO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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. 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: November 15 – December 31 of every year), or under certain special circumstances.

BlueAdvantage PPO serves a specific service area. If I move out of the area that BlueAdvantage 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 BlueAdvantage PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from BlueAdvantage PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date BlueAdvantage PPO coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, BlueAdvantage PPO provides reimbursement for all covered benefits, even if received out of network. Services authorized by BlueAdvantage PPO and other services contained in my BlueAdvantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUEADVANTAGE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with BlueAdvantage PPO, he/she may be compensated based on my enrollment in BlueAdvantage 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 and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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 BlueAdvantage 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 behalf of the individual under the laws of the State where the individual resides) 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 BlueAdvantage PPO or by Medicare.

Signature: _____ Today's Date: _____

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

Name: _____ Relationship to Enrollee: _____

Address: _____

Phone Number: () _____

Attestation of Eligibility for an Enrollment Periods:

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 making my annual enrollment period election (Nov. 15 - Dec. 31).
- I am making my annual open enrollment period election (Jan. 1 - Mar. 31).
- I am new to Medicare.
- I recently moved outside of the service area for my current plan.
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I live in or recently moved out of a Long Term Care Facility
(for example, a nursing home or long term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I am leaving employer or union coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- None of these statements applies to me.*

**Please contact BlueCross BlueShield of Tennessee at 1-800-292-5146 (TTY users should call 1-877-664-6422) to see if you are eligible to enroll. We are open 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30, you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.*

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____

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

Licensed Agent Use Only

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent: _____ Agent ID # _____ Date Received: _____

Agent Signature: _____