

**BlueAdvantage PFFS<sup>SM</sup>**  
**Enrollment Request Form**  
**Gold and Platinum 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: BlueAdvantage Enrollment**  
**1 Cameron Hill Circle, Suite 0005**  
**Chattanooga, TN 37402-0005**

**Fax Number: 423-535-8846**



A health plan with a Medicare contract.

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This document has been classified as confidential

## BlueAdvantage PFFS Enrollment Request Form

*Please contact BlueAdvantage PFFS if you need information in another language or format (Braille).*

### To Enroll in BlueAdvantage PFFS, Please Provide the Following Information

**Please check which plan you want to enroll in:**    BlueAdvantage PFFS Gold    BlueAdvantage PFFS Platinum

LAST Name	FIRST Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date <small>(MM/DD/YYYY)</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number (   )	Alternate Phone Number (   )
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Permanent Residence Street Address (P.O. Box is not allowed):

City	County	State	ZIP
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Mailing Address (Only if different from permanent residence address)	City	State	ZIP
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Emergency Contact (optional)	Phone No.: (   )	Relationship to You:
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E-mail Address (optional)

### 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 such as BlueAdvantage PFFS.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
____ - ____ - ____ - ____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

### Paying Your Plan Premium

**You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT), each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.**

*People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.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 get a bill each month.

**Please select a premium payment option:**

- Get 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 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.

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 PFFS?  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. Do you or your spouse work?  Yes  No

**Please check one of the boxes below if you would prefer that we send you information in another format:**

Audio Tape  CD

*Please contact BlueAdvantage PFFS 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 1 to September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.*

**STOP**

## Please Read This Important Information

BlueAdvantage PFFS, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept BlueAdvantage PFFS before each visit. Providers can find the plan's terms and conditions on our Web site at [www.bcbst.com/providers/BenefitHighlights.shtml](http://www.bcbst.com/providers/BenefitHighlights.shtml).

Once BlueAdvantage PFFS has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in BlueAdvantage PFFS. If BlueAdvantage PFFS isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

If you currently have health coverage from an employer or union, joining BlueAdvantage PFFS could affect your employer or union health benefits. If you have health coverage from an employer or union, joining BlueAdvantage PFFS may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join BlueAdvantage PFFS. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.

## Please Read and Sign Below

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

BlueAdvantage PFFS is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Medicare 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

As a Medicare Private Fee-for-Service plan, BlueAdvantage PFFS works differently than a Medicare supplement plan as well as other Medicare Advantage plans. BlueAdvantage PFFS pays instead of Medicare, and I will be responsible for the amounts that BlueAdvantage PFFS doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in BlueAdvantage PFFS.

Before seeing a provider, I should verify that the provider will accept BlueAdvantage PFFS. I understand that my health care providers have the right to choose whether to accept BlueAdvantage PFFS's payment terms and conditions every time I see them. I understand that if my provider doesn't accept BlueAdvantage PFFS, I will need to find another provider that will.

BlueAdvantage PFFS serves a specific service area. If I move out of the area that BlueAdvantage PFFS serves, I need to notify BlueAdvantage PFFS so I can disenroll and find a new plan in my new area. Once I am a member of BlueAdvantage PFFS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueAdvantage PFFS when I get it to know which rules I must follow to get coverage with this Private Fee-for-Service 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BlueAdvantage PFFS, he/she may be paid based on my enrollment in BlueAdvantage PFFS.

**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 PFFS 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 BlueAdvantage PFFS 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: \_\_\_\_\_

**Attestation of Eligibility for an Enrollment Period**

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 don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage, you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage, you can only change to another plan without Medicare 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 or I recently moved and this plan is a new option for me.  
I moved on (insert date): \_\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.

I no longer qualify for extra help paying for my Medicare prescription drugs.

I stopped receiving extra help on (insert date): \_\_\_\_\_

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.

I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on (insert date): \_\_\_\_\_.

None of these statements applies to me.\*

*\*Please contact BlueAdvantage PFFS 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 1 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: \_\_\_\_\_

SOA:  Yes  No

If "Yes," attach form or enter Reference #: \_\_\_\_\_