OMB No. 0938-1378
Expires: 7/31/2024

of Tennessee

2024 BlueAdvantage (PPO)℠

Enrollment Request Form

1 Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan must:

- ✓ Be a United States citizen or be lawfully present in the U.S.
- ✓ Live in the plan's service area
- ✓ Also have both: Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)

2 When do I use this form?

- 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

3 What do I need to complete this form?

- ☐ Your red, white, and blue Medicare card number
- ☐ Your permanent address and phone number (If you're unhoused, a PO Box, shelter or clinic address is OK).
- ☐ You must complete all items in Section 1. Section 2 is optional — you can't be denied coverage because you don't fill it out.

Reminders:

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 how you want your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

4 How do I get help with this form?

- Call BlueAdvantage at **1-800-292-5146**. TTY users can call **711**.
- En español: Llame a BlueAdvantage al **1-800-292-5146**, 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 para asistirle.
- Call Medicare at **1-800-MEDICARE (1-800-633-4227),** TTY **1-877-486-2048**.
- Visit **Medicare.gov** to learn more about when you can sign up for a plan.

5

What happens next? Send this completed and signed enrollment form to:
BlueCross BlueShield of Tennessee | ATTN: Medicare Advantage Enrollment
1 Cameron Hill Circle, Suite 0006 | Chattanooga, TN 37402-0006
Once we process your enrollment request form, we'll contact you.

of Tennessee

Section 1 — All fields on this page are required (unless marked optional)

Select the BlueAdvantage plan you want to join:

- ☐ Sapphire E (PPO) - **$0** per month
- ☐ Sapphire NE (PPO) - **$0** per month
- ☐ Sapphire SE (PPO) - **$0** per month
- ☐ Sapphire N GA (PPO)- **$0** per month
- ☐ Garnet W (PPO) - **$0** per month
- ☐ Garnet M (PPO) - **$0** per month
- ☐ Emerald NE (PPO) - **$31** per month
- ☐ Emerald SE (PPO) - **$45** per month
- ☐ Emerald W (PPO) - **$59** per month
- ☐ Emerald M (PPO) - **$59** per month
- ☐ Ruby NE (PPO) - **$47** per month
- ☐ Ruby SE (PPO) - **$92** per month
- ☐ Ruby W (PPO) - **$97** per month
- ☐ Ruby M (PPO) - **$107** per month
- ☐ Diamond NE (PPO) - **$89** per month
- ☐ Diamond SE (PPO) - **$149** per month
- ☐ Diamond M/W (PPO) - **$159** per month
- ☐ Freedom TN and N GA (PPO) - **$0** per month
  NO PART D PRESCRIPTION DRUG COVERAGE
- ☐ Extra TN and N GA (PPO)- **$23** per month

Your Medicare number ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

First name | Last name | Middle initial (OPTIONAL)

_____ /_____ /_____ | Sex: ☐ Female ☐ Male | (_____) _____ - _____

Birth date (MM/DD/YYYY) | Phone number

Permanent residence street address (PO BOX NOT ALLOWED)

City | County | State | ZIP code

Mailing address, if different from your permanent address (PO BOX ALLOWED)

City | County | State | ZIP code

Answer this important question:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueAdvantage?

- ☐ Yes (If Yes, you must provide the information below.)
- ☐ No

Name of other coverage | Member number for this coverage | Group number for this coverage

IMPORTANT — Read and sign below:

- ✓ I must keep Hospital (Part A) and Medical (Part B) to stay in BlueAdvantage.
- ✓ By joining this Medicare Advantage Plan, I acknowledge that BlueAdvantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on page 5).
- ✓ 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 when my BlueAdvantage coverage begins, I must get all of my medical and prescription drug benefits from BlueAdvantage. Benefits and services provided by BlueAdvantage and contained in my BlueAdvantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueAdvantage will pay for benefits or services that are not covered.
- ✓ 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 Phone number Relationship to enrollee

_____

Street address City State ZIP code

of Tennessee

Section 2 — All fields on this page are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1 **Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.**

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

2 **What's your race? Select all that apply.**

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

3 

- ☐ **Yes, I would like to receive my welcome packet via email.**
- ☐ **Yes, I would like to receive my materials via email when available.**

Select one or more:

- ○ Annual Notice of Changes (ANOC)
- ○ Benefits & Coverage Information
- ○ Wellness Tips & Checkup Reminders
- ○ Care Management
- ○ Claims Information

E-mail address: _____

Please contact BlueAdvantage at **1-800-831-2583** if you need information in an alternate format other than what's listed above. Our office hours are 8 a.m. to 9 p.m. ET, seven days a week. Our automated phone system may answer your call during weekends and holidays from **April 1 - Sept. 30**. Please leave your name and telephone number, and we'll call you back by the end of the next business day. TTY users can call **711**.

4 

- ☐ **Yes, I would like to receive available communications via text.**

Mobile phone number: (_____) _____ - _____

Note: By checking the above boxes I agree to enroll in email and/or mobile text communication service, and that I am 18 or older, or the legal guardian or personal representative of the applicant. BlueCross, its affiliates and its service providers may send me email and/or text communications that also go out to other members at the same time. Unencrypted email or text messages may possibly be intercepted and read by people other than those it's addressed to. By providing my email address, I accept the risks associated with emailing. Message and data rates may apply.

5 **List your Primary Care Provider (PCP), clinic, or health center:**

Provider's name: _____

Provider's address: _____

6 **Do you or your spouse work?** ☐ Yes ☐ No

Paying your plan premiums

If you have a monthly plan premium (including any late enrollment penalty that you currently have or may owe) you can pay by mail, Electronic Funds Transfer (EFT) or debit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

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 BlueAdvantage the Part D-IRMAA.

Please select a premium payment option:
(If you don't select a payment option, you will get a bill each month.)

☐ **Get a bill**

☐ **Electronic funds transfer** (EFT) from your bank account each month. If you select EFT, your first month's premium will be deducted from your banking account at the time CMS accepts your enrollment. Please provide the following:

Account holder name _____ Bank routing number _____

Bank account number _____ **Account type:** ☐ Checking ☐ Savings

☐ **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.)

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

Plan ID #: _____ Effective date of coverage: _____

ICEP/IEP: _____ 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 enrollee.

Licensed agent: _____ Agent ID #: _____ Date received: _____

Agent signature: _____

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Attestation of Eligibility for an Enrollment Period

of Tennessee

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 making my annual enrollment period election (October 15 through December 7).
- ☐ 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 qualification required to be in that 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.
- ☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- ☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
- ☐ I am enrolling in a 5-star Medicare plan.
- ☐ None of these statements apply to me.

Please contact **BlueAdvantage (PPO)**℠ at **1-800-292-5146**, TTY **711**, to see if you are eligible to enroll.

From **Oct. 1 to March 31**, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.