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of Tennessee

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association

2026 BLUEADVANTAGE TOTAL HEART & DIABETES (PPO C-SNP)SM

Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join this plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area
- Have one or more qualifying medical conditions (Diabetes Mellitus, Cardiovascular Disorders, and/or Chronic Heart Failure)

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?

Send your completed and signed 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.

How do I get help with this form?

Call BlueAdvantage at **1-800-292-5146**. 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 BlueAdvantage al **1-800-292-5146**, TTY **711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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

Select the BlueAdvantage plan you want to join:

☐ Total Heart and Diabetes E
(PPO C-SNP) - **$0** per month

☐ Total Heart and Diabetes W
(PPO C-SNP) - **$0** per month

☐ Total Heart and Diabetes Plus TN
(PPO C-SNP) - **$27.70** per month

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY) (___ ___/___ ___/___ ___ ___ ___)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

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 _____

To be eligible for enrollment, Medicare requires that you have one of the following qualifying diagnoses. Please check all that apply:

☐ Diabetes Mellitus ☐ Cardiovascular Disorders ☐ Chronic Heart Failure

Health care provider(s) who can verify your chronic condition(s)

Provider Name: _____

Provider Phone: _____

Provider Fax: (Optional) _____

Provider Address: _____

IMPORTANT: Read and sign below:

- I must keep both 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 below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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 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:	Address:
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 ☐ Other

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact BlueAdvantage at **1-800-831-2583** if you need information in an accessible format other than what's listed above. Our office hours are from **Oct. 1 to March 31**, you can call us from 8 a.m. to 9 p.m. ET, seven days a week. From **April 1 to Sept. 30**, we're available from 8 a.m. to 9 p.m. ET, Monday through Friday. TTY users can call **711**.

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

List your Primary Care Physician (PCP), clinic, or health center:

Are you enrolled in your State Medicaid program:

☐ Yes (If yes, please provide your Medicaid number.) _____

☐ No

I want to get available materials via email and/or text.

☐ email email address: _____

☐ text phone number: _____

Note: By checking the above boxes, I agree to enroll in email and/or mobile text communication and that I'm 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.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) 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. 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

(If you choose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Signature: _____

Relationship to enrollee: Select one. (If Agent/Broker, you must include your National Producer Number)

☐ Agent National Producer Number (Agents/Brokers only): _____

☐ Broker

☐ SHIP counselors

☐ Authorized representatives

☐ Other (third parties)

☐ Self

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: _____

Plan ID #: _____ Effective date of coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____

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.

BlueAdvantage is a PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal.

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 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 want to join a Special Needs Plan that tailors its benefits to my chronic condition.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency or by Federal, my state or my local government). One of the other statements here applied to me, but I was unable to make my enrollment because of the 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 requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.

☐ Because of an exceptional circumstance, I had a Special Enrollment Period and signed up for either:

- Premium-Part A (Hospital Insurance) and Part B (Medical Insurance)
- Only Premium-Part A (I already have Part B)
- Only Part B (I already have Part A and don't pay a premium for it)

I want to join a Medicare Advantage Plan (with or without drug coverage) because I now have both Part A and Part B.

☐ I pay a premium for Part A, and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.

☐ Individuals may disenroll from a Part D Plan (including PDPs and MA-PDs) to enroll in or maintain other creditable drug coverage including an MA 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.