BlueCross BlueShield of Oklahoma

Blue Cross MedicareRx℠ Medicare Prescription Drug Plan Individual Enrollment Form

Please contact Blue Cross MedicareRx if you need information in another language or format (Braille).

To enroll in Blue Cross MedicareRx, please provide the following information:

Please check the plan you want to enroll in:

☐ **Blue Cross MedicareRx Value (PDP)℠**
$95.60 per month

☐ **Blue Cross MedicareRx Choice (PDP)℠**
$19.90 per month

LAST Name: FIRST Name: Middle Initial: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: ___/___/_____ Sex: ☐ M ☐ F

Home Phone Number: (___)___-____

Alternate Phone Number: (___)___-____

Permanent Residence Street Address:

City: State: ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Street Address):

Street Address: City: State: ZIP Code: _____

Emergency Contact Name:

Phone Number: (___)___-____

Relationship to You:

Applicant Email Address:

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.

You must have Medicare Part A and Part B to join a Medicare prescription drug plan.

Name (as it appears on your Medicare Card): _____

Medicare Number: _____

Some boxes may be blank.

is Entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Applicant LAST name: FIRST name:

Attestation of Eligibility for and Enrollment Period

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.

☐ I am new to Medicare.	
☐ 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 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.	

If none of these statements applies to you or you're not sure, please contact Blue Cross MedicareRx at 1-888-285-2249 to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. TTY users should call 711.

Applicant LAST name:	FIRST name:

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 benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-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 Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Blue Cross 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% 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 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.

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:

☐ **Get a bill**

☐ **Electronic funds transfer (EFT) from your bank account each month.**
Please enclose a VOIDED check or 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.)

Applicant LAST name: FIRST name:

All fields for the next two questions are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

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

What's your race? Select all that apply.

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

Please answer the following questions:

1. Are you an existing Blue Cross and Blue Shield of Oklahoma Medicare member who is changing plans?
☐ **Yes** ☐ **No**

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.

Do you have existing prescription drug coverage? ☐ **Yes** ☐ **No**

Name of existing coverage: _____

Will you have other **prescription** drug coverage in addition to Blue Cross MedicareRx? ☐ **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): _____

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

- ☐ **Spanish**
- ☐ **Braille/Large Print**

Please contact Blue Cross MedicareRx at 1-888-285-2249 if you need information in another format or language than what is listed above. TTY users should call 711. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Applicant LAST name: FIRST name:

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 Cross 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 Cross MedicareRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross 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.

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

Blue Cross 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 to stay in this plan. It is my responsibility to inform Blue Cross 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 Cross MedicareRx will end that enrollment. 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.

Blue Cross MedicareRx serves a specific service area. If I move out of the area that Blue Cross 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 Cross MedicareRx network pharmacies. Once I am a member of Blue Cross 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 Cross MedicareRx when I get it to know which rules I must follow to get coverage.

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.

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

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.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and Blue Cross and Blue Shield of Oklahoma (BCBSOK), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSOK to use the Blue Cross and/or Blue Shield Service Marks in the State of Oklahoma, and that BCBSOK is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSOK and that no person, entity, or organization other than BCBSOK shall be held accountable or liable to Subscriber for any of BCBSOK's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSOK other than those obligations created under other provisions of this agreement.

Applicant LAST name:	FIRST name:

Please Read and Sign Below (continued)

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross MedicareRx will share my information with Medicare, and other plans if necessary, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law (see Privacy Act Statement below). 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 state law 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 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:

Medicare Prescription Drug Plan Use Only:

Plan ID #:		Effective Date of Coverage: ____ ____ / ____ ____ / ____ ____ ____ ____
☐ IEP	☐ AEP	☐ SEP (type):

Applicant LAST name: FIRST name:

Agent Information

To receive your compensation, you must complete the following information, and the enrollee must meet certain requirements (see information below). If you do not complete this section of the form, you will not be paid for this enrollee.

As the producer, I attest that the following information is true. By signing this enrollment form, I understand that providing false information can lead to disciplinary action up to and including loss of compensation payments and/or termination of the Blue Cross MedicareRx amendment.

Requirements for compensation payments:

- Be licensed and, where applicable, appointed;
- Successfully completed the 2023 Blue Cross MedicareRx training and certification program prior to marketing, selling, signing any enrollment form or conducting service for Blue Cross MedicareRx; **and**
- Enrolled a member who has been approved by CMS and has not canceled their enrollment prior to becoming effective.

I fulfilled the CMS annual training requirement by completing the 2023 AHIP and Blue Cross MedicareRx training and certification program requirements and did so before marketing, selling or conducting service with this enrollee.	☐ **Yes**	☐ **No**

Method of Scope		
I conducted a personal face-to-face marketing appointment with this applicant, as a result, I have a signed Scope of Appointment and understand that I may be asked to provide this documentation as part of the Blue Cross MedicareRx Monitoring & Oversight Program.	☐ **Yes**	☐ **No**
Please indicate the method by which this applicant's Scope of Appointment (SOA) was completed (Please check one). ☐ **Paper** ☐ **Electronic** ☐ **Telephone** ☐ **Seminar attendee — no SOA required**		
I provided the enrollee with information about eligibility requirements, enrollment periods, lock-in provisions, benefits, premiums, use of network pharmacies, billing options and the availability of Extra Help prior to his or her completing this enrollment form.	☐ **Yes**	☐ **No**

Please enter the following information carefully and legibly. Accurate and timely compensation payments depend on this information.

Writing Agent ID# (This is your BCBSOK assigned ID#): ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ (Not SSN or TID)	Phone Number: (____ ____ ____) ____ ____ ____ – ____ ____ ____ ____	
First Name:	Middle Initial:	Last Name:
Agent/Producer Signature: **X**		Date: ____ ____ / ____ ____ / ____ ____ ____ ____

Applicant LAST name:	FIRST name:

Electronic Application ID

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Prescription drug plans provided by Blue Cross and Blue Shield of Oklahoma, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.

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.