blue california

2021 Enrollment Request Form Blue Shield of California Medicare Rx Plan (PDP) Employer Group/Union Health Plan

Please contact Blue Shield of California Medicare Rx Plan if you need information in another language or format (Braille).

To enroll in Blue Shield of California Medicare Rx Plan, please provide the following Information:

Employer Group or Union Name

Group or Union No. (leave blank if not provided by your employer group or union)

Last name

☐ Mr. ☐ Mrs. ☐ Ms.

First name

Middle Initial (optional):

Birth date: (MM/DD/YYYY)

Sex ☐ M ☐ F

Phone number

Optional field: Alternate phone number

Permanent residence street address (P.O. Box is not allowed):

Street address

City

State

ZIP Code

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address

City

State

ZIP Code

Emergency contact name (optional)

Relationship to you (optional)

Phone number (optional)

Optional field: **E-mail address:**

☐ I am willing to receive required plan materials via email (i.e. enrollment notifications and Annual Notice of Changes) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations, and plan newsletter) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

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.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled to:	Effective Date:
HOSPITAL	(Part A) _____
MEDICAL	(Part B) _____

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

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

   If yes, retirement date (month/date/year): _____

   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

3. Do you or your spouse work? ☐ Yes ☐ No

4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Blue Shield of California Medicare Rx Plan? ☐ Yes ☐ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____

   ID # for Coverage: _____

5. 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 an accessible format:

☐ Spanish

☐ Large print

Please contact Blue Shield of California Medicare Rx Plan at **(800) 776-4466** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8.pm., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m. weekdays (8. a.m. to 5 p.m., Saturday and Sunday) from April 1 through September 30. TTY users should call **711**.

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 the Blue Shield of California Medicare Rx Plan, 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.

Please read and sign below

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

Blue Shield of California Medicare Rx Plan 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.

It is my responsibility to inform Blue Shield of California Medicare Rx Plan 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 any time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Shield of California Medicare Rx Plan 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 (for example, during your former employer group/union's open enrollment period or during the Annual Enrollment Period from October 15 – December 7), unless I qualify for certain special circumstances.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan 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 Shield of California Medicare Rx Plan network pharmacies. Once I am a member of the Blue Shield of California Medicare Rx Plan, 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 Shield of California Medicare Rx Plan when I get it to know which rules I must follow to get coverage.

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

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 the Blue Shield of California Medicare Rx Plan, he/she may be paid based on my enrollment in the Blue Shield of California Medicare Rx Plan.

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.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx Plan 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 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're the authorized representative, sign above, and fill out these fields:

Name:

Street Address:

City | State | ZIP code

Phone Number:

- -

Relationship to Enrollee:

Please return your completed enrollment form to your Benefits Administrator or mail to:

San Bernardino County - Employee Benefits and Services Division (EBSD)
175 West Fifth Street, First Floor
San Bernardino, CA 92415-0440

Office Use Only:

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

Meeting #: _____