blue california

2023 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)

First Name		☐ Mr ☐ Mrs ☐ Ms
Last Name		(optional): Middle Initial
Birth date: (MM/DD/YYYY)	Phone Number	(optional): ☐ Landline ☐ Cell
Sex: ☐ M ☐ F	Alternate Phone Number (optional):	(optional): ☐ Landline ☐ Cell

Permanent residence street address:

Street Address

City | State | ZIP Code

Mailing address, if different from your permanent address:

Street Address

City | State | ZIP Code

Optional: I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using on auto-dialer or artificial or prerecorded voice; standard data rates apply. ☐ Yes ☐ No

Participation is voluntary and you can opt-out at any time, for more information visit **blueshieldca.com/terms.**

Email address (Optional, but required for electronic communications)

☐ I would like to receive both required and non-required plan materials via email (i.e., enrollment notifications, Annual Notice of Change, benefit promotions, and plan newsletters) in place of mailed printed copies.

Not checking the box above means you will receive printed pion materials via moil. You may choose to go back to printed materials at any time by calling Customer Care at the number on your plan ID card.

Preferred communication channel: ☐ Email ☐ SMS (Text) ☐ Standard Mail ☐ Call

It's our goal to communicate with you in your preferred method. However, in some situations, we may need to adjust how we are providing you with information.

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: _____

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 **(888) 239-6469** 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. 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 Prescription 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. I can only be in one Medicare Prescription Drug Plan at any time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health 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 October 15 – December 7), or under 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. 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 with this Medicare Prescription Drug Plan.

I understand that beginning on the date my Blue Shield of California Medicare Rx Plan coverage begins, I must get all of my prescription drug services from Blue Shield of California. Prescription drugs authorized by Blue Shield of California and contained in my Blue Shield of California Medicare Rx Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD OF CALIFORNIA WILL PAY FOR THE SERVICES**.

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.

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.

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 send to:

Email: GroupMAPD@blueshieldca.com

Mail: Blue Shield of California

PO Box 948

Woodland Hills, CA 91365-9856

Fax: (877) 251-3660

Blue Shield of California is a PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and/or Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas and benefits.