2025 Enrollment Request Form for Blue Shield 65 Plus (HMO)

To enroll in Blue Shield 65 Plus, 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:	First name:	Middle initial:
Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female	
Home phone number:	Phone Type: ☐ Landline ☐ Mobile	

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

Street address:

City: State: ZIP code:

Mailing address, only if different from your permanent address:

Street address:

City: State: ZIP code:

The 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.

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, Cuban ☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a ☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ White
☐ **I choose not to answer.**

What is your gender?

☐ Woman
☐ Man
☐ Non-binary
☐ I use a different term: _____
☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay
☐ Straight, that is, not gay or lesbian
☐ Bisexual
☐ I use a different term: _____
☐ I don't know
☐ **I choose not to answer**

Select one if you want us to send you information in a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Customer Service at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week.

Email address:	**Mobile phone number:**

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of the required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

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 (MM/DD/YYYY): _____

   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 65 Plus? ☐ 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 and phone number of institution (number and street):

   _____

Optional field: **Please choose a primary care physician (PCP), clinic, or health center:**

Physician name or affiliated medical group:

Physician ID #:

Physician group name:

Current patient? ☐ Yes ☐ No

Please read and sign below

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

Blue Shield 65 Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a 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 65 Plus serves a specific service area. If I move out of the area that Blue Shield 65 Plus 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 Blue Shield 65 Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* (EOC) document from Blue Shield 65 Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield 65 Plus coverage begins, I must get all of my health care from Blue Shield 65 Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus and other services contained in my Blue Shield 65 Plus *Evidence of Coverage* (EOC) document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS 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 Blue Shield 65 Plus, he/she may be paid based on my enrollment in Blue Shield 65 Plus.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Blue Shield 65 Plus 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 the laws of the State 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 from Medicare.

Signature:	**Today's date: (MM/DD/YYYY)**

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:

For individuals helping enrollee with completing this form only

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

Name: _____

Signature: _____

Relationship to enrollee:

☐ SHIP Counselors ☐ Authorized representative

☐ Other (third party) ☐ Self

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 an HMO 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 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, benefits, and provider networks.