2026 Enrollment Request Form for Blue Shield of California Medicare Rx Plan (PDP)

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:	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 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.

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 **(888) 239-6469 (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. PT, seven days a week.

Email address:

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 required materials. 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) _____

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 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 and phone number of institution (number and street): _____

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* (EOC) 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 Medicare Rx Plan. Prescription drugs authorized by Blue Shield of California Medicare Rx Plan and contained in my Blue Shield of California Medicare Rx Plan *Evidence of Coverage* (EOC) document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD OF CALIFORNIA MEDICARE Rx PLAN 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 (MM/DD/YYYY):**

If you're the authorized representative, sign the previous page, 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: _____ Relationship to enrollee: _____

Signature: _____

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

Email: GroupMAPD@blueshieldca.com
Mail: Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856
Fax: (877) 251-3896