OMB No. 0938-1378
Expires: 7/31/2023

ENROLLMENT APPLICATION

HIGHMARK DELAWARE

INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Please make sure you locate the product and plan you are choosing to enroll in **and** your county of residence in the below list to determine the premium you will pay.

If you have questions or need assistance finding your premium, call us at the toll free number listed below and a knowledgeable representative will assist you in understanding your coverage and costs.

Freedom Blue PPO Signature

001: **$0**
Kent, New Castle, Sussex

Freedom Blue PPO Valor

003: **$0**
Kent, New Castle, Sussex

Freedom Blue PPO Distinct

002: **$33**
Kent, New Castle, Sussex

_____ Initial here to verify that you understand what the premium is for your plan, product and county.

ENROLLMENT APPLICATION

HIGHMARK DELAWARE

INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

WAYS TO ENROLL

Mail: Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Senior Markets
Enrollment Department
P.O. Box 535049
Pittsburgh, PA 15253-9801

Phone: Complete your application over the phone toll-free at **1-833-233-0401** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.

Online: Complete your application online at **medicare.highmark.com**

In person: Bring your application to a Medicare Options Seminar or other authorized locations. Call the toll-free number to find a meeting in your area.

DE

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

I understand that Freedom Blue PPO will notify me in writing of my confirmed effective date of enrollment in Freedom Blue PPO. I understand that, typically, my effective date will be the first of the month following the month in which Freedom Blue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in Freedom Blue PPO.

Highmark BCBSD Inc. is a Medicare Advantage plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. depends on contract renewal.

Freedom Blue PPO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and Part B. I can be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay 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 (RRB) benefit check each month. People with Limited Incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this 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. 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 when an enrollment period is available (Example: October 15 – December 7 of every year), or under special circumstances.

Freedom Blue PPO serves a specific service area. If I move out of the area that Freedom Blue PPO 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 Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Freedom Blue PPO 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 the Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

I understand that beginning on the date Freedom Blue PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Freedom Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in my Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM BLUE PPO 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 Freedom Blue PPO, he/she may be paid based on my enrollment in Freedom Blue PPO.

RELEASE OF INFORMATION:

By joining this Medicare health plan, I acknowledge that Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Freedom Blue PPO 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.

By providing your email address you are allowing for Highmark to contact you by email to provide information about Highmark's current Medicare product offerings, services, and Medicare related events as well as the opportunity to opt in to future email communications from Highmark.

PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Senior Solutions Company may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Senior Solutions Company's Notice of Privacy Practices is available on Highmark Blue Cross Blue Shield Delaware Company's Web site, or from the Highmark Highmark Blue Cross Blue Shield Delaware Company Privacy Department.

PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 benefit check or be billed directly by Medicare or RRB. DO NOT pay Freedom Blue PPO the Part D-IRMAA.

HIGHMARK DELAWARE

AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Name:	Agent NPN:	

In which channel was this application received?

- ❑ Face to Face Consultation
- ❑ Highmark Direct Store
- ❑ Pre-set Home Visit
- ❑ Medicare Options Seminar
- ❑ Member Benefits Forum
- ❑ Other

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth / /

Home Phone (with area code) ( )

Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue 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 CHECK WHICH PLAN YOU WANT TO ENROLL IN:

PLEASE DOUBLE CHECK THE PREMIUM FOR YOUR COUNTY ON PAGE 1

Freedom Blue PPO

❑ Signature – $_____ per month ❑ Valor – $_____ per month

❑ Distinct – $_____ per month

PAYING YOUR PLAN PREMIUM:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) or on the web with eBill each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill. Information about EFT and eBill will be included with your first bill.

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: ❑ Social Security ❑ RRB

(The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.)

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, another Hispanic, Latino/a or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **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
- ❑ Somoan
- ❑ Vietnamese
- ❑ White
- ❑ **I choose not to answer**

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield Delaware health plan? Yes ❑ No ❑

   If YES, name of plan: _____

2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? Self: .....Yes ❑ No ❑
   Spouse:.....Yes ❑ No ❑

   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year):_____

Typically, you may enroll in a Medicare Advantage Plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage Plan outside of this 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.

Annual Enrollment Period (October 15th through December 7th):

If you are enrolling during the annual enrollment period from October 15th through December 7th of each year, and none of the options below apply, we will automatically process your enrollment as part of the Annual Enrollment Period – you do not need to fill out this page.

NEW TO MEDICARE OR A CHANGE TO YOUR COVERAGE

- ❑ I am new to Medicare.
- ❑ I recently involuntarily lost my creditable prescription coverage ("creditable" means coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).
- ❑ I am leaving or have left employer or union coverage on _____ (insert date).
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

RECENT CHANGE IN RESIDENCE

- ❑ I recently moved or plan to move outside of the service area for my current plan, or I recently moved or plan to move and this plan is a new option for me. _____ (insert move date).
- ❑ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home). I moved/ will move into/ out of the facility on _____ (insert date).
- ❑ I recently obtained lawful presence status in the U.S. I got this status on _____ (insert date).
- ❑ I recently was released from incarceration. I was released on _____ (insert date).

CHANGE IN INCOME OR SPECIAL NEEDS/PLAN QUALIFICATIONS

- ❑ 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 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 belong to a pharmacy assistance program provided by my state.
- ❑ I recently left a PACE plan (Program of All-Inclusive Care for the Elderly) on _____ (insert date).
- ❑ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (insert date).
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, lost Medicaid) on _____ (insert date).

OTHER REASON

- ❑ I am in a plan that is identified as consistent poor performer.
- ❑ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ❑ I am enrolling in a 5-Star Medicare plan.
- ❑ None of the above apply.

3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? Yes ❑ No ❑

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)	PCP/NPI #

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* Yes ❑ No ❑

Are you enrolled in your State Medicaid program? . . . . . Yes ❑ No ❑

If "YES," please provide your Medicaid Number: _____

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): _____

STOP! **Please read this important information. If you currently have health care coverage from an employer or union, joining Freedom Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Freedom Blue PPO. Read the communications your employer or union sends you.**

If you have questions, visit their Web site or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.

READ AND SIGN BELOW

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 by Freedom Blue PPO or by Medicare.

Signature	Today's Date

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

❑ I would like to receive my materials in a language other than English.

❑ I would like to receive my materials in an accessible format (Braille, Large Print, etc).

Please contact Freedom Blue PPO at **1-833-233-0401** (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.

HIGHMARK. Delaware

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں(TTY: 711) ۔

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసెస్టెన్స్ సర్వీసెస్, ఛార్జి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。