MEDICARE ADVANTAGE

2023

# Enrollment Application

## BlueSaver (HMO)
## Senior Blue (HMO)
## Forever Blue (PPO)
## Freedom (PPO)

**If you have any questions, we're here to help!**

**medicare.highmark.com**

1-866-456-8140
(TTY 711)

| | |
|---|---|
| **October 1 – March 31** | **8 a.m. to 8 p.m., 7 days a week** |
| **April 1 – September 30** | **8 a.m. to 8 p.m., Monday – Friday** |



HIGHMARK WESTERN NEW YORK

ENR-388 (9-22)

Y0086_22_9921_C

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

# MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

**Who can use this form?**

People with Medicare who want to join a Medicare Advantage Plan

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

**When do I use this form?**

You can join a plan:

- Between October 15 and December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

**What do I need to complete this form?**

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

**Reminders:**

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

**What happens next?**

Send your completed and signed form to:

**Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY)**

PO BOX 4208

Buffalo, NY 14240

Once we process your request to join, we'll contact you.

**How do I get help with this form?**

Call Highmark BCBSWNY at 1-866-456-8140. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En espanol:** Llame a Highmark BCBSWNY al 1-866-456-8140 (los usuarios de TTY pueden llamar 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en espanol y un representate estara disponible para asistirle.



**IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that are not about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

# Section 1 — All fields on this page are required (unless marked optional)

**Please check which plan you want to enroll in:**

- ☐ **BlueSaver (HMO)** $0 per month
- ☐ **Senior Blue Basic (HMO)** $0 per month
- ☐ **Senior Blue 601 (HMO)** $0 per month
- ☐ **Senior Blue Select (HMO)** $55 per month
- ☐ **Senior Blue 651 (HMO)** $117 per month
- ☐ **Freedom Valor (PPO)** $0 per month
- ☐ **Freedom Nation (PPO)** $22 per month
- ☐ **Forever Blue Value (PPO)** $142 per month
- ☐ **Forever Blue 751 (PPO)** $201 per month

**First Name** **Last Name** **Middle Initial**

**Birth Date** M M / D D / Y Y Y Y

**Sex** ☐ M ☐ F

**Phone Number** ( )

**Permanent Residence Street Address (Don't enter a PO Box):**

**City** **County** **State** **ZIP Code**

**Mailing address, if different from your permanent address (PO Box allowed):**

**Street Address**

**City** **State** **ZIP Code**

# Your Medicare information

**Medicare Number** _ _ _ _ - _ _ _ - _ _ _ _

# Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Highmark BCBSWNY?

☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

# IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Highmark BCBSWNY's Medicare Advantage plan.
- By joining this Medicare Advantage Plan, I acknowledge that Highmark BCBSWNY will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Highmark BCBSWNY coverage begins, I must get all of my medical and prescription drug benefits from Highmark BCBSWNY. Benefits and services provided by Highmark BCBSWNY and contained in my Highmark BCBSWNY "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Highmark BCBSWNY will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 are the authorized representative, you must sign above and provide the following information:

**Name**

**Address**

**Phone Number**

( )

**Relationship to Enrollee**

# Section 2 — All fields on this page 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, another Hispanic, Latino/a or Spanish origin
- ❑ **I choose not to answer.**
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **I choose not to answer**

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

☐ Spanish ☐ Chinese ☐ Russian ☐ Other Language (call for availability)

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD

**Please contact Highmark BCBSWNY at 1-866-456-8140 if you need information in an accessible format or language other than what is listed above. TTY users should call 711. Our office hours are:**

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Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your primary care physician (PCP), clinic, or health center:

## 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) each month, quarterly, biannually, or annually. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit check each month.**

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Highmark BCBSWNY the Part D-IRMAA.

## PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR§§422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

# Attestation of Eligibility for an Enrollment Period

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.

## 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).

# Attestation of Eligibility for an Enrollment Period

## Other Reason

- ☐ I am in a plan that is identified as a 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.

We are open:

| | |
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Highmark BCBSWNY is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Every year, Medicare evaluates plans based on a 5-star rating system.

**Office Use Only**

Name of Staff Member/Agent/Broker (if assisted in enrollment): _____

Plan ID # _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible _____

Broker/Agent Name :_____ ID # _____

Agency_____

# Notice of Nondiscrimination

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)
- 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, please call the customer service number on the back of your member ID card or 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, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

**For assistance in English, call the customer service number listed on your member ID card.**

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

**বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।**

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

**Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας**.

**Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit**.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ígíí bich´j´dahodootnih.