Medicare PLUS Blue℠ Group PPO

Enrollment request for Sheet Metal Workers Local 7 Zone 2 26533-600

<BCBSM ID #>

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please contact Medicare Plus Blue Group PPO if you need information in another language or format.

Please provide the following information. Please print.			
☐ Mr. ☐ Mrs. ☐ Ms.	First name	Middle initial	Last name
Date of birth (mm/dd/yyyy) ___/___/___	Sex ☐ Male ☐ Female	Daytime phone number ( )	Alternate phone number ( )
Permanent residence address *(cannot be a post office box)*		City	State
ZIP code	County	E-mail address (optional)	
Mailing address *(if different from your permanent residence address)*			
Street address _____			
City _____		State _____ ZIP code _____	
Optional information			
Emergency contact name _____			
Relationship to you _____		Telephone number ( ) _____	

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.

Medicare Plus Blue is a PPO plan with a Medicare contract.
Enrollment in Medicare Plus Blue depends on contract renewal.

Please respond to all questions	
1. **Do you have other drug coverage, including other private insurance, workers compensation, VA benefits or state pharmaceutical assistance programs?** If yes, please provide: Company name: _____ Name of other drug plan: _____ ID/policy number for this coverage: _____	☐ **Yes** ☐ **No**
2. **Are you a resident of a long-term care facility, such as a nursing home?** If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: ( )	☐ **Yes** ☐ **No**
3. **Do you have end-stage renal disease (ESRD)?** If you answered yes and no longer need regular dialysis or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.	☐ **Yes** ☐ **No**
4. **Are you enrolled in Medicaid?** If yes, please provide your Medicaid number: _____	☐ **Yes** ☐ **No**
5. **Please enter the name of your primary doctor:** _____	**Primary doctor's telephone:** **( )** _____

This enrollment application is part of your Medicare Plus Blue Group PPO enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

Please contact Medicare Plus Blue Group PPO Customer Service at 1-866-684-8216 (TTY users call 711) if you need information in an alternate format or need assistance in a language other than English. Customer Service hours are 8:30 a.m. to 5 p.m., ET, Monday through Friday (October 1 through March 31 8 a.m. to 9 p.m., ET, seven days a week). You can also visit us at **www.bcbsm.com/medicare**.

Please read and sign below.

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

Medicare Plus Blue Group PPO is a health plan with a Medicare contract. I will need to keep my 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 or Medicare Prescription Drug Plan. If the Medicare Advantage plan has a Medicare Prescription Drug Plan, enrollment in the Medicare Advantage PPO plan will automatically end my enrollment in another Medicare 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 do not 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.

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, or under certain special circumstances. As a Medicare Advantage PPO member, Medicare Plus Blue Group PPO works differently than a Medicare supplemental plan. Medicare Plus Blue Group PPO pays instead of Medicare, and I will be responsible for the amounts that Medicare Plus Blue Group PPO does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in Medicare Plus Blue Group PPO.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will or my out-of-pocket costs may be greater. Out-of-Network/non-contracted providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Medicare Plus Blue Group PPO serves a specific service area. If I move out of the area that Medicare Plus Blue Group 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 Medicare Plus Blue Group PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Medicare Plus Blue Group PPO when I receive it to know which rules I must follow in order to receive 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 if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Medicare Plus Blue Group PPO, he/she may be paid based on my enrollment in Medicare Plus Blue Group PPO.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

By joining this Medicare health plan, I acknowledge that the Medicare Plus Blue Group PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medicare Plus Blue Group PPO who will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 by Medicare Plus Blue Group PPO or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flier.	
Signature	**Today's date** (mm/dd/yyyy)

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

Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone number: _____

Relationship to enrollee: _____

Please send your completed enrollment application to:

Fund Office
Re: Sheet Metal 7:2
6525 Centurion Drive
Lansing, MI 48917

or

Fax to: 1-517-321-7508