2024 Blue Cross Medicare Advantage (PPO) West Region Application

BlueCross BlueShield Minnesota

Application Instructions

Please read before completing

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 Prescription Drug 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 – December 7 each year (for coverage starting January 1)
- Within three 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 Sections A – D and F – H. The items in Section E 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 (RRB) benefit.

What happens next?
Send your completed and signed form to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 982807
El Paso, TX 79998-2807

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

How do I get help with this form?
Call Blue Cross at 1-877-662-2583. TTY users call 711.

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

En español: Llame a Blue Cross al 1-877-662-2583 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness
- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

2024 Individual Medicare Advantage West Region Application
(Please print or type)

A Enrollee information

Name Last First MI **Gender** ☐ Male ☐ Female

Permanent Address (P.O. Box not allowed) Street City State ZIP

Phone ( ) **Birthdate** **County**

Mailing Address (P.O. Box is allowed) Street City State ZIP

Email Address

Your Medicare information

Medicare Number: __ __ __ __- __ __ __ - __ __ __ __

B Plan selection

1. Select a plan

- ☐ Freedom Blue℠ (MA Only) $0 per month
- ☐ Medicare Advantage Core (MAPD) $0 per month
- ☐ Medicare Advantage Comfort (MAPD) $64.00 per month
- ☐ Medicare Advantage Choice (MAPD) $106.00 per month
- ☐ Medicare Advantage Complete (MAPD) $222.00 per month

C Enrollment Period determination

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 for any statement that 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

☐ I am enrolling during the Annual Enrollment period, October 15 through December 7, for a January 1 effective date. (This application must be received by December 7 for enrollment to be effective January 1.)

New to Medicare

1. ☐ I am new to Medicare.
2. ☐ I was notified about getting Medicare after my Part A and/or Part B coverage started. I received this notification on _____**(insert date)**.
3. ☐ I am within my initial coverage election period as I have recently applied for Medicare Part B and am applying prior to my Part B effective date.

A change to your coverage

4. ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (This enrollment period is open from January 1 through March 31 each year, for a first of the following month effective date. This enrollment application must be received by March 31).
5. ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ (**insert date**). Requested effective date _____.
6. ☐ I am leaving employer or union coverage on _____ (**insert date**). Requested effective date _____.
7. ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

Recent change in residence

8. ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on _____ (**insert date**). Requested effective date _____.
9. ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ (**insert date**).
10. ☐ I recently was released from incarceration. I was released on _____ (**insert date**).
11. ☐ I recently obtained lawful presence status in the United States. I got this status on _____ (**insert date**).

Change in income or special needs/plan qualifications

12. ☐ 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.
13. ☐ 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**).
14. ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in the level of Medicaid Assistance, or lost Medicaid) on _____ (**insert date**).
15. ☐ 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**).
16. ☐ 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.
17. ☐ 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**).
18. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact Blue Cross Medicare Advantage at 1-877-662-2583 to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., Central Time. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. TTY users call 711.

D Please answer these questions

1. Do you or will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Cross Medicare Advantage?

   ☐ **Yes** ☐ **No**

   If **YES**, you must list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID# for this coverage:	Group # for this coverage:
_____	_____	_____

E Please answer these additional questions. These responses 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, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaskan Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

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

- ☐ Spanish
- ☐ Other

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

- ☐ Braille
- ☐ Large print
- ☐ Audio CD

Please contact Blue Cross at 1-877-662-2583 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., Central Time. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. TTY users call 711.

F Payment Method

Get a Bill: ☐ Monthly ☐ Semi-Annually ☐ Quarterly ☐ Annually

Deducted from: ☐ Social Security ☐ RRB

Social Security and RRB only allow monthly deductions.

New Medicare Advantage members will receive their first invoice by mail with instructions about automatic payment options. Members changing Medicare Advantage plans will keep their existing payment arrangement. To cancel an automatic payment or change a payment frequency, please call the customer service number on the back of your member ID card.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by any of the payment options listed above.

NOTE: 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. DON'T pay Blue Cross Medicare Advantage the Part D-IRMAA.

G Authorization and acknowledgments

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Cross Medicare Advantage.
- By joining this Medicare Advantage plan, I acknowledge that Blue Cross Medicare Advantage 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.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Blue Cross Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Blue Cross Medicare Advantage. Benefits and services provided by Blue Cross Medicare Advantage and contained in my Blue Cross Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Cross Medicare Advantage will pay for benefits or services that are not covered.
- The information on this application is correct to the best of my knowledge. I understand that if I intentionally provide false information on this application, I will be disenrolled from the plan.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (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.

H Please read and sign below:

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 application; and 2) documentation of this authority is available upon request by Medicare.

Signature _____ Date _____

☐ I authorize my licensed agent, identified below, to enter and submit my application information online to Blue Cross electronically.

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

Name: _____

Address: _____

Phone Number: (_____) _____ Relationship to Enrollee: _____

Please return this form by email to Enrollment.Forms@bluecrossmn.com or fax to (651) 662-6315.
Applicants may also return this form in the envelope provided or mail to Blue Cross and Blue Shield of Minnesota P.O. Box 982807, El Paso, TX 79998-2807.

FOR AGENT/PRODUCER USE ONLY

Agency Code _____ Producer Number _____

Producer Name _____

Producer Signature _____ Date _____

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

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

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
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

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

image_0006_NDL_Portrait (09/16)

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

image_0002R02_General_Portrait (01/17)

THIS PAGE IS INTENTIONALLY LEFT BLANK