MASSACHUSETTS

2022 MEDICARE HMO BLUE (HMO)

To Complete Your Group Enrollment Form:

Be sure to complete all information, sign, and date your enrollment form. Return the completed form(s) to your employer. We'll contact you in writing when we receive your enrollment form, and then again to notify you of your effective date of coverage.

To enroll in Medicare HMO Blue, please provide the following information:

Last Name | First Name | Middle Initial | Mr. ☐ Mrs. ☐ Ms. ☐

Birth Date (MM/DD/YYYY) (__ __/__ __/__ __ __ __) | Sex ☐ M ☐ F | Email Address | Home Phone Number ( ) –

Permanent Residence Address (P.O. Box is not allowed)
Number and Street | Alternate Phone Number ( ) –

City | State | ZIP Code

Mailing Address (only if different from your Permanent Residence Address)
Number and Street

City | State | ZIP Code

Emergency Contact Name | Phone Number | Relationship to You

Please provide your Medicare insurance information.

Please use 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.

Employer Use Only

Group Name		Group Number	Requested Effective Date
Office Use Only			
ICEP/IEP	OEP	AEP	SEP (type)

Please read and answer these important questions.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

☐ Check here if you want us to send you information in a language other than English.
Language:_____

☐ Select if you want us to send you information in an accessible format.
Large print: _____

If you need information in an accessible format other than what's listed above please call us at **1-800-200-4255**. Our office hours are 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week, except April 1 through September 30 when we are open Monday through Friday. TTY users can call **711**.

1. Some individuals may have other drug coverage, including other private insurance,TRICARE®, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Medicare HMO Blue? Yes ☐ No ☐

If yes, please 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

2. Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance, workers' compensation, or VA benefits? Yes ☐ No ☐

What kind of coverage?	Name of your insurance company

3. 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 and Address of Institution	Phone Number of Institution

4. Are you enrolled in your state Medicaid program? Yes ☐ No ☐

If yes, please provide your Medicaid Number: ___ ___ ___ ___ — ___ ___ ___ — ___ ___ ___ ___

5. Do you or your spouse work? Yes ☐ No ☐

Please choose the name of a Primary Care Provider (PCP):

Please provide your PCP's ID number	Are you a current patient?

Yes ☐ No ☐

Please read and sign below:

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

Medicare HMO Blue is a Medicare Advantage plan and has a contract with the federal government. I'll need to keep my Medicare 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 prescription drug plan. It's 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. I may leave this plan or make changes only at certain times of the year, or under certain special circumstances, by sending a request to Medicare HMO Blue or by calling **1-800-MEDICARE** (**1-800-633-4227**) 24 hours a day/7 days a week. (TTY users should call **1-877-486-2048**.)

Medicare HMO Blue serves a specific service area. If I move out of the area that Medicare HMO Blue serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I'm a member of Medicare HMO Blue, I have the right to appeal plan decisions about payment or services if I disagree. I'll read the Evidence of Coverage from Medicare HMO Blue 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 beginning on the effective date of my Medicare HMO Blue plan coverage, I must get all of my health care from Medicare HMO Blue, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Medicare HMO Blue and other services contained in my Medicare HMO Blue Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR MEDICARE HMO BLUE WILL PAY FOR THE SERVICES.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that my Medicare HMO Blue 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'll 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 from Medicare.

Your Signature	Today's Date (__/__/____) MM DD YYYY

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

Name	Phone Number
Address	Relationship to Enrollee

For Member Service: call **1-800-200-4255** (TTY: **711**), April 1 through September 30, 8:00 a.m. to 8:00 p.m., Monday through Friday, and October 1 through March 31, 8:00 a.m. to 8:00 p.m., seven days a week. or visit **bluecrossma.com/medicare**.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

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