Blue Shield 65 Plus℠ (HMO) and Blue Shield 65 Plus Choice Plan (HMO)
Short Enrollment Request Form

Name of Plan You are Enrolling in: _____

Name: _____	**Member Number**: _____

Home Phone Number:

Permanent Street Address (P.O. Box is not allowed):

City:	State:	ZIP code:

Mailing Address (only if different from your Permanent Street Address):

Street Address: City: State: ZIP code:

Please fill out the following:
I am currently a member of the _____ plan in _____ (Blue Shield of California) with a monthly premium of $_____.
I would like to change to the _____ plan in _____ (Blue Shield of California). I understand that this plan has different health benefits and a monthly premium of $_____.

Name of chosen Primary Care Physician (PCP):

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

___Spanish ___Large Print

Please contact Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan at (800) 776-4466 if you need information in another format or language than what is listed above. Our office hours are 7 a.m. to 8 p.m., seven days a week, from October 1 through February 14. After February 14, your call will be handled by our automated phone system on weekends and holidays. TTY users should call 711.

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or by 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 Check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 the RRB. Do NOT pay Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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.

If you don't select a payment option, you will get a bill each month.

Please select a late enrollment penalty payment option:

__ Get a monthly bill.

__ Electronic Funds Transfer (EFT) from your bank account each month. Please fill out the Blue Shield Easy$Pay form if you're not already using EFT. If you do not have a copy of the form, please call us and we will send you one.

__ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

[STOP]

Please Read This Important Information

Please Read and Sign Below:

Blue Shield 65 Plus and Blue Shield 65 Plus Choice Plan are plans that have a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield 65 plus or Blue Shield 65 Plus Choice Plan, he/she may be paid based on my enrollment in Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan.

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 Blue Shield 65 Plus or Blue Shield 65 Plus Choice 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 will be disenrolled from the plan. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan coverage begins, I must get all of my health care from Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan and other services contained in my Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS OR BLUE SHIELD 65 PLUS CHOICE PLAN WILL PAY FOR THE SERVICES**.

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.

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_____

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: ____

Producer information:
TMO/GMO/Other name (please print name)_____
TMO/GMO/Other ID No._____
Producer name (please print name)_____ Producer ID No._____
Producer phone number: (___) ____-_____ Producer signature: _____
Producer email address: _____
Date application received by producer: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete pre-sale kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.