2023 Group Medicare Advantage (PPO) MAPD Enrollment Form

Group Medicare Advantage is a Medicare Advantage product offered by Blue Cross and Blue Shield of Minnesota (Blue Cross), an organization licensed by the state of Minnesota that holds a contract with the Centers for Medicare & Medicaid Services (CMS) to offer this product.

Enrollment Form Instructions
Please read before completing.

In addition to meeting the eligibility requirements for your Employer Group, you are eligible to enroll in Group Medicare Advantage only if:

- You are enrolled in the federal Medicare program for Part A (Hospital insurance) and Part B (Medical insurance).
- You reside in the United States and/or territories

Other important information

- If you have questions concerning your enrollment, please contact your group benefit plan administrator.
- Blue Cross determines when your enrollment form is considered complete based on Medicare enrollment guidelines.
- Your enrollment in Group Medicare Advantage is subject to approval from CMS. If your enrollment is not approved by CMS, we will notify you immediately.
- You must continue to pay your Part B Medicare premium (this premium is usually deducted from your Social Security check).
- These contracts have a minimum anticipated loss ratio of 85 percent. This means that on the average, you may expect that $85 of every $100 in premiums that you pay is returned to you as benefits over the life of the coverage.
- Senior LinkAge provides free health insurance information and helps explain your Medicare rights and protections. You can contact Senior LinkAge at 1-800-333-2433 and ask for a Health Insurance Counselor.

To enroll in Group Medicare Advantage, please make sure you have completed and forwarded all necessary information to your group benefit plan administrator.

1. Carefully review and complete all sections of this form in full. Make sure you sign and date this enrollment form. Missing or incomplete information may cause a delay in the effective date of your coverage.
2. If you and your spouse wish to enroll, please complete separate enrollment forms.
3. Enrollment forms must be received by the last business day of the month in order to be effective the first day of the month following receipt of your completed form.
4. If the enrollee has a Durable Power of Attorney (POA), Durable POA for Health Care, or legal guardian or conservator, the authorized representative may be asked to provide proof that he or she is authorized to act on the enrollee's behalf.
5. Send the enrollment form to your group benefit plan administrator and keep a copy for your records.

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

2023 Group Medicare Advantage (PPO) MAPD Enrollment Form

For Office Use Only
Group Contractholder: ____________________
Group Number: ____________________
Enrollee's Effective Date of Coverage: _______ - _______ - _______

A Enrollee information

(Please type or print)

1. Enrollee's name ______________________________
Last First MI

2. Telephone number _______ – _______ – _________

3. Enrollee's permanent address ______________________________
(P.O. Box is not allowed) Street

____
City State ZIP County

Mailing address ______________________________
(P.O. Box is allowed) Street

____
City State ZIP County

4. Gender ☐ Male ☐ Female

5. Date of birth Month Day Year
_____ - _____ - _____

Please provide your Medicare insurance information

6. 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 the Social Security Administration or the Railroad Retirement Board (RRB)

Name (as it appears on your Medicare card):

____

Medicare Number: ______________________________

Is entitled to: Effective date (mm/dd/yyyy)
Hospital (Part A) __________________
Medical (Part B) __________________

You must have Medicare Parts A and B to join a Medicare Advantage plan.

B Please answer these questions

You must select **Yes** or **No** for questions 1-4 below. This information is **not** used for health screening. Questions 5-8 are optional and **do not** impact your enrollment into the plan.

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

If YES, will you have health coverage through your or your spouse's current or former employer in addition to this coverage? ☐ Yes ☐ No

Employer name: ______________________

Employer address: ______________________

Policyholder name: ______________________

Policy number: ______________________

2. Will you be enrolled in your state Medicaid program in addition to this coverage? ☐ Yes ☐ No
If **YES,** please provide the eight-digit Medical Assistance ID number that is on your Minnesota Health Care Programs card: ______________________

3. Do you or will you have other prescription drug coverage in addition to this plan like Federal Employee Health Benefits coverage or State Pharmaceutical Assistance Programs? ☐ 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:
______________	______________	______________

4. 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 of facility ______________ Phone number of facility ______________

Address of facility (number and street): ______________________

B Please answer these questions (continued)

5. Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

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

- ☐ Spanish
- ☐ Other

6. 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.**

7. What's your race? Select all that apply.

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

8. 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 have indicated you need information in a language other than English or need information in one of the listed accessible formats, or in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. daily, 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 can call 711.

C Authorization and acknowledgments

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

Group Medicare Advantage is a Medicare Advantage plan and has a contract with the federal government.

I will 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. It is 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. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: Annual Enrollment Period from October 15 to December 7), or under certain special circumstances.

Group Medicare Advantage serves a specific service area. **If I move out of the area that Group Medicare Advantage 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 Group Medicare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Group Medicare Advantage when I get it to know which rules I must follow to get coverage.

Release of information: By joining this Medicare health plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the 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 and agree that Blue Cross may share my past, current and future health and account records with my network providers about services I've received from both in-network and out-of-network providers. These records may be used by my network providers as needed to manage or coordinate my care and to improve the quality of that care.

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____**Date**____________________

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

Name: ____

Address: ____

Telephone number: (______) ____

Relationship to enrollee: ____

Please confirm with your group benefit plan administrator where to return completed form.

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

BlueCross BlueShield Minnesota

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.

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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.

နမ့်ၤကတိၤကညီကျိာ်ဒီး, တၢ်ကဟ့ၣ်နၤကျိာ်တၢ်မၤစၢၤကလီတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTY အဂီၢ်, ကိး 711 တက့ၢ်.

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.

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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.

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