OMB No. 0938-1378 Expires: 6/30/2026

2025 Platinum Blue℠ (Cost) Application

BlueCross BlueShield Minnesota

Instructions

Please read before completing.

You are eligible to enroll in Platinum Blue if:

- You are enrolled in Medicare for Part A (Hospital insurance) and Part B (Medical insurance), or Part B only. (Note: If you have Medicare Part B only, you only have coverage for Medicare Part B services. You do not have coverage for hospital, skilled nursing facilities and related services covered by Medicare Part A.)
- You reside in the service area, which includes 21 counties in Minnesota.
- To determine if your county is in the service area, please visit our website at bluecrossmn.com/medicare or call the number listed under Other important information.
- You do not have permanent end-stage renal disease (ESRD) (kidney disease requiring dialysis or a kidney transplant) unless you are currently enrolled in a Blue Cross plan and you developed ESRD while a member of the plan.

Other important information

- If you have questions concerning your enrollment or need help filling out this application, please call Blue Cross at 1-877-662-2583 (TTY 711). 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.
- Blue Cross determines when your application is considered complete based on Medicare enrollment guidelines.
- Your enrollment in Platinum Blue is subject to approval from the Centers for Medicare & Medicaid Services (CMS). If your enrollment is not approved by CMS, we will notify you immediately.
- You must continue to pay your Medicare Part B premium (this premium is usually deducted from your Social Security check).
- **If you are currently enrolled in a Medicare Supplement plan, you must follow the appropriate process to cancel it. Contact your plan for information on how to cancel the plan. If you are replacing a Medicare Supplement policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.**
- Are you currently enrolled in another Medicare Advantage or Medicare Cost plan? If YES, enrolling in Platinum Blue will cancel your membership in your current plan.
- These contracts have a minimum anticipated loss ratio of 65 percent. This means that on the average, you may expect that $65 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, helps explain your Medicare rights and protections, and can provide you with information about Medicare Supplement and Medicare Cost plans (like Platinum Blue). You can contact Senior LinkAge at 1-800-333-2433 and ask for a Health Insurance Counselor.

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.

To enroll in Platinum Blue, please make sure you have completed and forwarded all necessary information to Blue Cross.

1. Carefully review and complete all sections of this application in full. Make sure you sign and date this application. 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 application.
3. If you are newly enrolling in Medicare Part B, you may apply up to three (3) months prior to your Medicare Part B effective date, the month of, and up to three (3) months after your eligibility date.
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.

2025 Individual Platinum Blue Application

(Please print or type)

A Enrollee information

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

Permanent Address (P.O. Box not allowed, individuals experiencing homelessness or who are in the Safe at Home program may enter a P.O. Box.)

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

Select the plan you want to join:

- ☐ Platinum Blue Core plan – $37.00
- ☐ Platinum Blue Choice plan – $129.00
- ☐ Platinum Blue Complete plan – $214.00
- ☐ Platinum Blue Core with Rx – $60.40
- ☐ Platinum Blue Choice with Rx – $176.20
- ☐ Platinum Blue Complete with Rx – $282.20

C Enrollment Period determination. Required for all enrollees.

Typically, you may enroll in a Medicare Plan only during the Annual Enrollment Period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare plan outside of the Annual Enrollment Period.

If you are applying for prescription drug coverage under this plan and are newly eligible for Medicare Part A and Part B, select "I am new to Medicare."

Please read the following statements carefully and check the box if the statement 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; enrollment will 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)**.

A change to your coverage

3. ☐ 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 _____.
4. ☐ I am leaving employer or union coverage on _____ **(insert date)**. Requested effective date _____.
5. ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

C Enrollment Period determination. Required for all enrollees. (continued)

Recent change in residence

6. ☐ 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 _____.
7. ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ **(insert date).**
8. ☐ I recently was released from incarceration. I was released on _____ **(insert date).**
9. ☐ 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

10. ☐ 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)**.
11. ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid Assistance, or lost Medicaid) on _____ **(insert date)**.
12. ☐ 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)**.
13. ☐ I was affected by an emergency or major disaster (as declared by the Federal 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.
14. ☐ 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)**.
15. ☐ Other _____
16. ☐ I am enrolling in the Platinum Blue Core, Choice or Complete medical plan options. My effective date will be the first day of the month following receipt of my completed application and confirmation of enrollment by CMS.

If none of these statements applies to you or you're not sure, please contact Platinum Blue at 1-877-662-2583 to see if you are eligible to enroll. TTY users can call 711. 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.

D You must select YES or NO for each question below. This information is not used for health screening.

1. Have you ever been diagnosed with End-Stage Renal Disease (ESRD)? If **YES** and you do not need regular dialysis, or have had a successful kidney transplant**, please attach a note or records** from your doctor showing that you do not need dialysis or have had a successful kidney transplant.	☐ Yes ☐ No
2. Do you or your spouse work? If **YES**, will you have health coverage through you or your spouse's current or former employer in addition to Platinum Blue? Employer Name: _____ Employer Address: _____ Policyholder Name: _____ Policy Number: _____	☐ Yes ☐ No ☐ Yes ☐ No
3. Will you be covered by Medical Assistance through your state Medicaid program in addition to Platinum Blue? If **YES**, please provide the eight-digit Medical Assistance ID number that is on your Minnesota Health Care Programs card. _____	☐ Yes ☐ No
4. Do you or will you have other prescription drug coverage in addition to Platinum Blue with Rx like Federal Employee Health Benefits coverage, TRICARE, or VA benefits? 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: _____	☐ Yes ☐ No

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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **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.**

What is your gender? Select one.

☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term:_____

☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual

☐ I use a different term:_____ ☐ I don't know ☐ **I choose not to answer**

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

Language: ☐ Spanish ☐ Other

Accessible format: ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Blue Cross at 1-877-662-2583 if you need information in an accessible format or language other than what is listed above. TTY users can call 711. 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.

F Payment Method

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

Deducted from: ☐ Social Security ☐ Railroad Retirement Board (RRB)

Social Security and Railroad Retirement Board (RRB) only allow monthly deductions.

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

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

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

NOTE: People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, people who qualify will not have a late enrollment penalty. Many people qualify for these savings and do not 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 call 1-800-325-0778. You can also apply for Extra Help online at **ssa.gov/medicare/part-d-extra-help**.

G Authorization and acknowledgements

Please read this important information

If you currently have health coverage from an employer or union, joining Platinum Blue with Rx could affect your benefits. If you have health coverage from an employer or union, joining Platinum Blue with Rx and selecting the Medicare Prescription Drug benefit may change how your current coverage works.
Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

After carefully reading all statements in this section, please sign Section H of this form. Keep a copy for your records.

By completing this application, I agree to the following:

- Platinum Blue is a Medicare health plan and I will need to keep my Medicare Part B while enrolled in this plan. I can be in only one Medicare health plan at a time.
- Platinum Blue with Rx is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage.
- It is my responsibility to inform Platinum Blue with Rx of any prescription drug coverage that I have or may get in the future. I can only be in one prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in Platinum Blue with Rx will end that enrollment.
- I know that I may disenroll from this plan at any time by sending a written request to Blue Cross or by calling 1-800-MEDICARE, (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Platinum Blue serves a specific service area. **If I permanently move out of the area that Platinum Blue serves or leave the area for more than nine (9) consecutive months, I need to notify the plan so I can disenroll and find a new plan in my new area.**
- I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Platinum Blue with Rx network pharmacies.
- Once I am a member of Platinum Blue, I have the right to appeal plan decisions about payment for services if I disagree.
- I will read the Evidence of Coverage document from Blue Cross when I receive it to understand my rights, benefits, plan premium, cost-sharing amounts, and responsibilities as a member of this Medicare Cost plan.
- I understand that beginning on the date that Platinum Blue coverage starts, in order for Platinum Blue to fully cover my medical services, (except for emergency or urgently-needed services which are covered at the same cost sharing amount, regardless of the network status of the provider) all of my health care must be provided or arranged by Platinum Blue. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as determined by the Medicare program. I may also be liable for charges not covered by Medicare.
- I understand that Medicare beneficiaries are generally not covered by Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Platinum Blue and emergency services outlined in my Platinum Blue Evidence of Coverage document (also known as a member contract or subscriber agreement) are covered. Minnesota law requires coverage of emergency services provided by a nonparticipating provider, with or without prior authorization.
- 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.

G Authorization and acknowledgments - continued

- I understand that Blue Cross will send me written notification of the effective date of my enrollment in Platinum Blue.
- Counseling services may be available in Minnesota to provide advice concerning medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare heath plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Platinum Blue 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. This release of information authorization is valid as long as I am continually insured with the insurer or it is revoked.

H Please read and sign below:

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this enrollment 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 Platinum Blue or Medicare.

Signature _____ Date_____

☐ I authorize my licensed agent, identified below, to enter and transmit 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 _____

Platinum Blue is a Medicare-approved Cost plan offered by Blue Cross and Blue Shield of Minnesota. Enrollment in Platinum Blue depends on contract renewal.

Notice of Nondiscrimination and Accessibility

At Blue Cross and Blue Shield of Minnesota and Blue Plus, we treat everyone fairly. We don't exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). We follow federal civil rights laws and don't discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

Need these services? Call **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

Discrimination is against the law.

If we failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting our Nondiscrimination Civil Rights Coordinator:

Email: Civil.Rights.Coord@bluecrossmn.com
Telephone: 1-800-509-5312
Mail: Blue Cross and Blue Shield of Minnesota
ATTN: Civil Rights Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at bluecrossmn.com/NDL, or from the Nondiscrimination Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services

- electronically through the Office for Civil Rights complaint portal: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201
- or by phone at: 1-800-368-1019, 1-800-537-7697 (TDD)

Civil rights complaint forms are available at 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.

နမ့်ကတိၤကသိကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကွ်.

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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