BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Nebraska Medicare Advantage

How to enroll in Blue Cross and Blue Shield of Nebraska Medicare Advantage

We're here to help.

- Need help completing your application?
- Have questions?
- Want more information?

Please call us at **1-844-899-6060**. Our hours are 8 a.m. to 8 p.m., Central time, seven days a week from Oct. 1 through Feb. 14; 8 a.m. to 8 p.m., Central time, Monday through Friday from Feb. 15 through Sept. 30. TTY users call **711**.

Ready to enroll?

Enroll online by visiting **medicare.nebraskablue.com** or the Centers for Medicare & Medicaid Services Online Enrollment Center at **www.medicare.gov/find-a-plan.**

OR

Enroll using this form. Here are some helpful hints:

- Use a black or blue ink pen.
- Complete a separate form for each person enrolling. If you need another copy, make a photocopy or call us.
- Print your answers, except where your signature is required (page 6).
- Make sure you complete each section of the application.
- Mail your application promptly.

Please do not send your payment with this application. Just keep the yellow copy for your records and return the completed form in the postage-paid envelope, or mail it to:

Blue Cross and Blue Shield of Nebraska
PO Box 696565
San Antonio, TX 78269

What happens next?

- Once CMS approves your application, we'll send you a letter within 10 days, confirming your enrollment.
- We'll bill you based on your plan choice or automatically deduct your premium from your Social Security check, if you choose that option.
- You'll also receive an information packet about the benefits you get with your Blue Cross and Blue Shield of Nebraska Medicare Advantage coverage.

Blue Cross and Blue Shield of Nebraska is an HMO and HMO-POS plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Nebraska Medicare Advantage depends on contract renewal.

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2017 INDIVIDUAL ENROLLMENT FORM
Medical and Prescription Drug Coverage
(Coverage Effective 2017)

Office Use Only:

Please contact Blue Cross and Blue Shield of Nebraska Medicare Advantage at **1-844-899-6060**, if you need information in another format or language. Our hours are 8 a.m. to 8 p.m., Central time, seven days a week from Oct. 1 through Feb. 14; 8 a.m. to 8 p.m., Central time, Monday through Friday from Feb. 15 through Sept. 30. TTY users call **711**.

Sec. 1 To enroll in Blue Cross and Blue Shield of Nebraska Medicare Advantage, please provide the following information.

Blue Cross and Blue Shield of Nebraska Medicare Advantage is available in the following counties: Cass, Dodge, Douglas, Lancaster, Sarpy and Saunders
Please check which plan you want to enroll in:

☐ Option 1 - Blue Cross Blue Shield Nebraska MA Core - $0 premium

☐ Option 2 - Blue Cross Blue Shield Nebraska MA Choice - $44 premium

☐ Mr. ☐ Mrs. ☐ Ms.	First name	Middle initial	Last name
Birth date (M M / D D / Y Y Y Y)	Sex ☐ Male ☐ Female	Daytime phone number	Alternate phone number
Permanent residence street address *(no P.O. Box)*		City	State
ZIP code	County	E-mail address *(optional)*	

Mailing address *(only if different from your permanent residence street address)*

Street address _____

City _____ State _____ ZIP code _____

Please choose a primary care physician (PCP)

Regular doctor _____

Phone number ( ) _____

Sec. 2 Please provide your Medicare insurance information.

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

  - OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

SAMPLE ONLY

Name _____

Medicare Claim Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Sex ☐ M ☐ F

Is Entitled To: Effective Date

HOSPITAL (Part A) ___/___/___

MEDICAL (Part B) ___/___/___

Sec. 3 Please read the following statements and check the box that applies to you.

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 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.

- ☐ I am new to Medicare.
- ☐ 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) _____.
- ☐ I recently was released from incarceration. I was released on (insert date)_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE® program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was disenrolled from a Medicare Special Needs Plan (SNP) because I no longer have a special needs status. I was disenrolled from the SNP on (insert date) _____.
- ☐ Other.

_____

If none of these statements applies to you or you're not sure, please contact Blue Cross and Blue Shield of Nebraska at **1-844-899-6060** to see if you're eligible to enroll. Our hours are 8 a.m. to 8 p.m., Central time, seven days a week from Oct. 1 through Feb. 14; 8 a.m. to 8 p.m., Central time, Monday through Friday from Feb. 15 through Sept. 30. TTY users call **711**.

Sec. 4 Paying your plan premium

(***Plans with $0 premium:*** **If we determine that you owe a late enrollment penalty or if you currently have a late enrollment penalty, we need to know how you would prefer to pay it.)** ***All plans:*** **You can pay your monthly plan premium (including any late enrollment fee that you may owe) by mail or an automatic withdrawal from your bank account. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you're assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you'll be notified by the Social Security Administration. You'll 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 the Part D-IRMAA to Blue Cross and Blue Shield of Nebraska.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you are eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.**

Sec. 4 *continued* Paying your plan premium

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'll bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you'll get a bill each month. We encourage you to choose automatic deductions so you don't have to receive a monthly statement or write a check.

You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check. If you select a plan with a monthly premium over the Social Security limit, the premium can't be taken out of your Social Security check. Instead you must pay your premium directly to us, including any unpaid premiums. Please understand that it may take up to three months for SSA deductions to start. Any unpaid premiums will be billed directly to you.

Please select a premium payment option:

☐ Automatic withdrawal from your bank account each month. Please allow up to 60 days to process your request. Please pay any premium bill you may receive while your request is processing. Future monthly premiums will be automatically withdrawn from your specified account on or about the **first** day of every month.

Please enclose a **VOIDED** check:

Account holder name: _____

Bank routing number: _____
(first set of numbers located on left side of check)

Bank account number: _____
(second set of numbers located in the center of check)

Account type: ☐ Checking ☐ Savings

☐ Get a monthly bill.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB 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.)

Sec. 5 Please read and answer these important questions

1. Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or state pharmaceutical assistance programs.

   Will you have other **medical or prescription drug coverage** in addition to a Blue Cross and Blue Shield of Nebraska Medicare Advantage plan?

   ☐ Yes ☐ No If "yes," please list your other coverage and identification (ID) number(s) for coverage:

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

2. 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		Address	
City	State	ZIP code	Telephone

3. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you for additional information.

   Note: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Blue Cross and Blue Shield of Nebraska organization as a commercial member or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998.

Sec. 5 *continued* **Please read and answer these important questions**

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

If you are currently enrolled in a Medicare supplement plan, you must first disenroll from the Medicare supplement plan, because submitting this application doesn't automatically disenroll you. Please contact Blue Cross and Blue Shield of Nebraska Medicare Advantage at **1-844-899-6060** if you need information in another format or language. Our hours are 8 a.m. to 8 p.m., Central time, seven days a week from Oct. 1 through Feb. 14; 8 a.m. to 8 p.m., Central time, Monday through Friday from Feb. 15 through Sept. 30. TTY users call **711**.

Sec. 6 **Please read this important information and sign**

If you currently have health coverage from an employer or union, joining a Blue Cross and Blue Shield of Nebraska plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Blue Cross and Blue Shield of Nebraska plan. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

- Blue Cross and Blue Shield of Nebraska 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 be in only 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. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.
- Blue Cross and Blue Shield of Nebraska Medicare Advantage serves a specific area. If I move out of the area that Blue Cross and Blue Shield of Nebraska 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 a Blue Cross and Blue Shield of Nebraska Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Blue Cross and Blue Shield of Nebraska 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 date Blue Cross and Blue Shield of Nebraska Medicare Advantage coverage begins, I must get all of my health care from Blue Cross and Blue Shield of Nebraska, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Cross and Blue Shield of Nebraska and other services contained in my Blue Cross and Blue Shield of Nebraska Medicare Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, NEITHER MEDICARE NOR BLUE CROSS AND BLUE SHIELD OF NEBRASKA WILL PAY FOR THE SERVICES.**
- I understand that if I am getting help from a sales agent, broker or other individual employed by or contracted with Blue Cross and Blue Shield of Nebraska, he/she may be paid based on my enrollment in a Blue Cross and Blue Shield of Nebraska Medicare Advantage plan.

Sec. 6 *continued* **Please read this important information and sign**

Release of Information:
By joining this Medicare health plan, I acknowledge that Blue Cross and Blue Shield of Nebraska will release my information to Medicare and other plans as needed for treatment, payment and health care operations. I also acknowledge that Blue Cross and Blue Shield of Nebraska will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that 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 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 content 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 form and 2) documentation of this authority is available upon request from Medicare.

Signature	Today's date

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

Name			Phone number
Address	**City**	**State**	**ZIP code**
Relationship to enrollee			

AGENT/OFFICE USE ONLY (Applicants do not complete this section)

Note to producing agents: *2017 paper enrollment forms must be keyed into* ***www.nebraskablue.com/accessmedicare*** *within 24 hours of accepting the paper enrollment form.*

Date producing agent accepted paper enrollment from Medicare eligible applicant: ☐☐/☐☐/☐☐☐☐

Print name of producing agent: _____ _____
First Name Last Name

Signature of producing agent: _____

Email of producing agent: _____

Agent Number: ☐☐☐☐☐☐☐☐☐☐ Agent tax ID: ☐☐☐☐☐☐☐☐☐

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of person entering enrollment information online (print first/last name): _____ _____
First Name Last Name