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

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both: Medicare Part A (Hospital Insurance)
Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

Your Medicare number (the number on your red, white, and blue Medicare card)
Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional -- you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 -December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

- Send your completed and signed form to:
  Blue Cross and Blue Shield of Nebraska
  PO Box 3248
  Omaha, NE 68172

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Blue Cross and Blue Shield of Nebraska at **844-899-6060**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Blue Cross and Blue Shield of Nebraska al 844-899-6060/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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.

BlueCross BlueShield Nebraska

2025 INDIVIDUAL ENROLLMENT FORM
Medical Coverage
(Coverage Effective 2025)

Office Use Only:

Please contact Blue Cross and Blue Shield of Nebraska Medicare Advantage at **844-899-6060**, (TTY users should call 711)if you need information in an accessible format or language. We are open 8 a.m. to 9 p.m. CT, seven days a week from Oct. 1 through Mar. 31; 8 a.m. to 9 p.m. CT, Monday-Friday from Apr. 1 through Sep. 30.

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

Sec. 1 **All fields on this page are required (unless marked optional)**

Blue Cross and Blue Shield of Nebraska Medicare Advantage is available in the following counties: Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Cass, Cedar, Chase, Clay, Colfax, Cuming, Custer, Dawson, Deuel, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler, York

Please check which plan you want to enroll in:

- ☐ Option 1 - Blue Cross Blue Shield Nebraska MA Core (HMO) - $0 monthly premium
- ☐ Option 2 - Blue Cross Blue Shield Nebraska MA Access (PPO) - $25 monthly premium
- ☐ Option 3 - Blue Cross Blue Shield Nebraska MA Connect (PPO) - $0 monthly premium
- ☐ Option 4 - Blue Cross Blue Shield Nebraska MA Secure (PPO) - $91 monthly premium

FIRST name	LAST name	Optional: Middle initial

Birth Date (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Phone number

Optional: Email Address

Permanent residence street address (Do not enter a PO Box)

City	Optional: County	State	ZIP code

Mailing address - *if different from your permanent address - PO Box allowed*

Street address

City	State	ZIP code

Your Medicare information:

Medicare number: __ __ __ __ – __ __ __ – __ __ __ __

Your Medicare information:

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 **prescription drug coverage** (like VA, TRICARE) in addition to a Blue Cross and Blue Shield of Nebraska Medicare Advantage Plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

Special Enrollment Periods: Please 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 am enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ 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) _____ .
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ 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 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) _____ .
- ☐ 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) _____ .
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency 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 natural disaster.
- ☐ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ☐ Other.

If none of these statements applies to you or you're not sure, please contact Blue Cross and Blue Shield of Nebraska at 888-488-9850 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 9 p.m. CT, seven days a week from Oct. 1 through Mar. 31; 8 a.m. to 9 p.m. CT, Monday-Friday from Apr. 1 through Sep. 30.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Cross and Blue Shield of Nebraska.
- By joining this Medicare Advantage Plan, I acknowledge that Blue Cross and Blue Shield of Nebraska will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Blue Cross and Blue Shield of Nebraska coverage begins, I must get all of my medical and prescription drug benefits from Blue Cross and Blue Shield of Nebraska. Benefits and services provided by Blue Cross and Blue Shield of Nebraska and contained in my Blue Cross and Blue Shield of Nebraska "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Cross and Blue Shield of Nebraska will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this 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 enrollment, and 2) Documentation of this authority is available upon request by Medicare.

Signature	**Today's date**

*If you are the authorized representative of the enrollee **(not agent/broker)**, sign above and fill out these fields:*

Name	Phone number

Address	City	State	ZIP Code

Relationship to enrollee

Sec. 2 **All fields on this page 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
- ☐ **I choose not to answer.**

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

Sec. 2 continued **All fields on this page are optional**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Blue Cross and Blue Shield of Nebraska at 888-488-9850 if you need information in an accessible format or another language. Our office hours are 8 a.m. to 9 p.m. CT, seven days a week from Oct. 1 through Mar. 31; 8 a.m. to 9 p.m. CT, Monday-Friday from Apr. 1 through Sep. 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your primary care physician (PCP) if you have one, clinic, or healthcare center.

Regular doctor: _____

Does the member wish to receive materials electronically (Online)? ☐ Yes ☐ No ☐ No Answer

Member email address: _____

If you are currently enrolled in a Blue Cross and Blue Shield of Nebraska Medicare Supplement plan, by signing this application and enrolling in a Medicare Advantage plan, your Blue Cross and Blue Shield of Nebraska Medicare Supplement plan will be automatically canceled. For all other carriers, please contact your Medicare supplement plan to disenroll. If you need information in an accessible format or language, please contact Blue Cross and Blue Shield of Nebraska Medicare Advantage at **844-899-6060** (TTY users should call 711) if you need information in an accessible format or language. We are open 8 a.m. to 9 p.m. CT, seven days a week from Oct. 1 through Mar. 31; 8 a.m. to 9 p.m. CT,Monday-Friday from Apr. 1 through Sep. 30.

Part A effective date: _____

Part B effective date: _____

Requested Coverage Effective Date (pending CMS approval): _____

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or an automatic withdrawal from your bank account each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Cross and Blue Shield of Nebraska the Part D-IRMAA.

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.

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 ***ssa.gov/medicare/part-d-extra-help***

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.

☐ 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 the first day of each month or next business day.

Please enclose a VOIDED check or provide the following:

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.I get monthly benefits from:

☐ Social Security ☐ RRB

(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.)

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

Note to producing agents: *2025 paper enrollment forms must be keyed into* ***NebraskaBlue.com/AccessMedicare*** *within 24 hours of accepting the paper enrollment form.*

Date producing agent accepted paper enrollment from Medicare Eligible applicate: _____

Print name of producing agent: _____
FIRST name LAST name

Signature of producing agent: _____

Email of producing agent: _____

Agent number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Agent tax ID: ___ ___ ___ ___ ___ ___ ___ ___ ___

This section to be completed by an individual other than the agent:

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

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

BlueCross BlueShield Nebraska

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Nebraska does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Nebraska:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 888-488-9850, TTY 711 between 8 a.m. to 9 p.m., Central time, seven days a week from Oct. 1 through March 31; 8 a.m. to 9 p.m., Central time, Monday through Friday April 1 through Sept. 30.

If you believe that Blue Cross and Blue Shield of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Manager, Medicare Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001
888-488-9850, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance, is available to help you.

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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf. For quick processing, use the OCR online portal to file a complaint.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-488-9850 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-488-9850 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-488-9850 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-488-9850 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-488-9850 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-488-9850 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-488-9850 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-488-9850 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-488-9850 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-488-9850 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه ، فوري، ليس عليك سوى الاتصال بنا على 1-888-488-9850 (TTY: 711). سيقوم شخص ما يتحدث العربية خدمة مجانية

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-488-9850 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-488-9850 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-488-9850 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-488-9850 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-488-9850 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-488-9850 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Y0139_NENonDiscrimNoticeMLI_C
50-101-MA (04-17-24)
Form CMS-10802
(Expires 12/31/25)

Form Approved
OMB# 0938-1421