Medicare PLUS Blue Group
Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield of Michigan contracts with the federal government and is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

EMPLOYER/UNION GROUP HEALTH PLAN ENROLLMENT REQUEST FORM

To enroll in Medicare Plus Blue Group, please provide the following information:

Last Name	First Name	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date (/ /) (MM /DD/YYYY)	Sex ☐ Male ☐ Female	Social Security Number (Optional)	Preferred Phone Number ( )

Permanent Residence Street Address (Cannot be a Post Office Box)

City	State	Zip Code

Mailing Address (Only if different from your Permanent Residence Address)

Street Address _____ City _____ State _____ Zip Code _____

Please provide your Medicare insurance information:

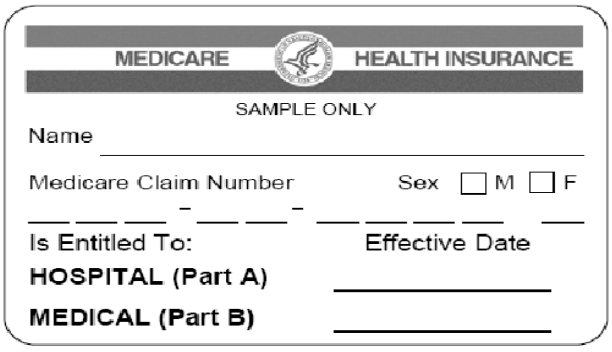
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match **your** red, white and blue Medicare card (not your spouses).

- OR –

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

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



Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No
If yes, retirement date (month/date/year): _____
If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
If yes, name of spouse: _____
Name of dependents: _____

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

4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to BCBSM Medicare Plus Blue Group? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: ID # for coverage:

6. 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 Institution: _____
Address & Phone Number of Institution (number and street):

BCBSM Use Only: Enter Medicare Contract #:

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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 ☐ Arabic ☐ Other _____

☐ Braille ☐ Audio Tape ☐ Large Print ☐ Other _____

Visit us at www.bcbsm.com or call Medicare Plus Blue Group Member Services at 1-866-684-8216. Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday. (TTY/TDD users call 1-800-579-0235)

Please Read This Important Information

Medicare Plus Blue Group, a Medicare Advantage Private Fee-for-Service plan, works differently than your existing plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, or otherwise agree to treat you, you will not be able to receive covered services from them under this plan. Providers can find the plan's terms and conditions on our Web site at http://www.bcbsm.com/ma.

Please read and sign below:

By completing this enrollment application, I agree to the following:
Medicare Plus Blue Group is a Medicare Advantage Private Fee-for-Service plan and has a contract with the Federal government. I will need to keep my 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. If the Medicare Advantage Private Fee-for-Service plan has a Medicare prescription drug plan, enrollment in the Medicare Advantage Private Fee-for-Service plan will automatically end my enrollment in another Medicare prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire plan 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, or under certain special circumstances.

As a Medicare Private Fee-for-Service plan, Medicare Plus Blue Group works differently than a Medicare supplement plan. Medicare Plus Blue Group pays instead of Medicare, and I will be responsible for the amounts that Medicare Plus Blue Group does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in Medicare Plus Blue Group.

Before seeing a provider, I should verify that the provider will accept Medicare Plus Blue Group. I understand that my health care providers have the right to choose whether to accept a Private Fee-for-Service plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept Medicare Plus Blue Group, I will need to find another provider that will.

EMPLOYER/UNION GROUP HEALTH PLAN
ENROLLMENT REQUEST FORM

Medicare Plus Blue Group serves a specific service area. If I move out of the area that Medicare Plus Blue Group 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 Medicare Plus Blue Group, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medicare Plus Blue Group when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage Private Fee-for Service plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Medicare Plus Blue Group, he/she may be compensated based on my enrollment in Medicare Plus Blue Group.

Counseling services may be available in my State to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare Private Fee-for-Service 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 Medicare Plus Blue Group 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 my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 by Medicare Plus Blue Group or by 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