

Blue Shield of California Medicare Rx Plan Enrollment Form

Employer group prescription drug benefit

This form is for retirees who want to enroll in the Blue Shield of California Medicare Rx Plan, an Enhanced Group Prescription Drug Benefit plan. To enroll, please fill in all the information requested below. Read the terms and conditions on the back, and then sign and date.

Important! You must have Medicare Part A or Part B (or both) to join the Blue Shield of California Medicare Rx Plan.

Employer name _____ Group number _____
(you'll find this number on your member ID card)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	First name		Middle initial
Birth date (__/__/____) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (optional)	Home phone number ()	E-mail address
Permanent residence street address (no P.O. boxes):				
Street		City	State	ZIP code
Mailing address (only if different from your permanent residence address):				
Street		City	State	ZIP code

Please provide your Medicare insurance information

Please refer to 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: _____	
Medicare claim number: _____ - _____ - _____ - _____	
Is entitled to	Effective dates
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Please answer the following questions

1. Some individuals may have other 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 in addition to the Blue Shield of California Medicare Rx Plan offered through your employer or union? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID No. for this coverage: _____

Group No. 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 institution: _____

Address and phone number of institution: _____
(number and street)

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

Please contact Blue Shield of California Medicare Rx Plan at (888) 239-6469. TTY users should call (888) 239-6482 if you need information in another format or language than what is listed above. Our office hours are 7 a.m. to 8 p.m., seven days a week.



Please read this important information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining the Blue Shield of California Medicare Rx Plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Blue Shield of California Medicare Rx Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue Shield of California Medicare Rx Plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on who to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

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

Blue Shield of California Medicare Rx Plan 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 coverage. It is my responsibility to inform Blue Shield of California Medicare Rx Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at any time. If I am currently in a Medicare prescription drug plan, my enrollment in Blue Shield of California Medicare Rx Plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for certain special circumstances.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan serves, 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 to access Blue Shield of California Medicare Rx Plan benefits, except under limited, non-routine circumstances when I cannot reasonably use Blue Shield of California Medicare Rx Plan network pharmacies. Once I am a member of the Blue Shield of California Medicare Rx 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 Shield of California Medicare Rx Plan when I receive it to know which rules I must follow to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare’s), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield, he/she may be compensated based on my enrollment in Blue Shield of California Medicare Rx Plan. 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 prescription drug plan, I acknowledge that Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx 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 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 Blue Shield of California or by Medicare.

Your signature: _____ Today’s date: _____

If you are the authorized representative – i.e., Power of Attorney or Legal Guardian (see description above) – you must provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____ - ____ Relationship to enrollee: _____

Please return your completed enrollment form to your Benefits Administrator or mail to:

Blue Shield of California Medicare Rx Plan
PO Box 927
Woodland Hills, CA 91365

Medicare Prescription Drug Plan Use Only:

Plan ID No.: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative Signature: _____