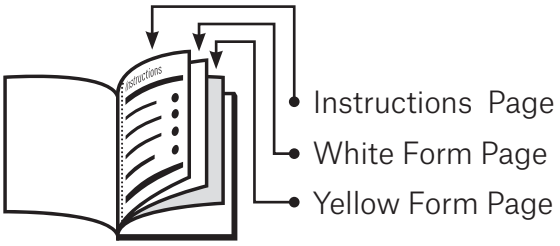
Enrollment Form Instructions

This enrollment form uses carbonless copy paper that includes a white and yellow sheet for each page of the form. Before you begin writing, please follow the instructions below to ensure your handwriting doesn't go through to the other pages.

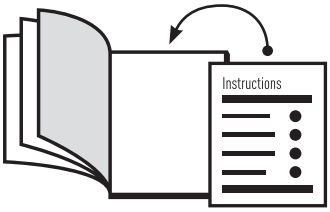
STEP 1

This enrollment form instructions page is perforated. Detach this from the booklet for your use.



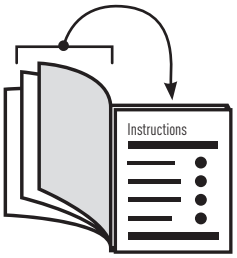
STEP 2

Turn the first white and yellow pages of the enrollment form to the left and place this instruction page on top of the next white page.



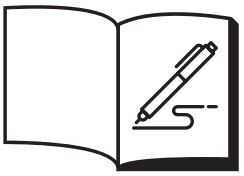
STEP 3

Turn the white and yellow pages back to the right to lay on top of the instruction page.



STEP 4

You are now ready to fill out the first page of the form.



When you have finished filling out the first page, follow the steps above for the remaining pages.

Once completed and signed, please mail the white copy to Blue Advantage using the included postage-paid business reply envelope.

Louisiana | Please call 1-800-363-9152 if you need information in another language or format. TTY users call the national relay service toll free at 711.

TO ENROLL IN A PLAN, PLEASE PROVIDE THE FOLLOWING:

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __ /__ __ /__ __ __ __) M M D D Y Y Y Y	Sex: ☐ M ☐ F	Primary Phone Number: ( ) ☐ Cell ☐ Home ☐ Other	Secondary Phone Number: ( ) ☐ Cell ☐ Home ☐ Other
Permanent Residence Street Address: (P.O. Box is not allowed)			Parish:
City:		State:	ZIP Code:
Mailing Street Address (only if different from your Permanent Residence Address):			
City:		State:	ZIP Code:
Email Address (optional):			
Emergency Contact:			Phone Number: ( )
Relationship to You:			

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section:

- Fill out this information as it appears on your Medicare card.

-OR-

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

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To	**Effective Date:**
Hospital (Part A)	__ __ /__ __ /__ __ __ __
Medical (Part B)	__ __ /__ __ /__ __ __ __

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

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:

☐ **Blue Advantage (HMO) 005: $0 per month**
Includes Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster parishes

☐ **Blue Advantage (HMO) 006: $0 per month**
Includes Caldwell, Catahoula, Concordia, East Carroll, Franklin, Jackson, LaSalle, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll and Winn parishes

☐ **Blue Advantage (HMO) 007-1: $0 per month**
Includes Ascension and East Baton Rouge parishes

☐ **Blue Advantage (HMO) 007-2: $0 per month**
Includes East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge and West Feliciana parishes

☐ **Blue Advantage (HMO) 008-1: $0 per month**
Includes Jefferson, Lafourche, Orleans, St. Charles and Terrebonne parishes

☐ **Blue Advantage (HMO) 008-2: $0 per month**
Includes Assumption, Plaquemines, St. Bernard, St. James and St. John the Baptist parishes

☐ **Blue Advantage (HMO) 009-1: $0 per month**
Includes St. Tammany and Tangipahoa parishes

☐ **Blue Advantage (HMO) 009-2: $0 per month**
Includes Washington Parish

☐ **Blue Advantage (HMO) 010-1: $0 per month**
Includes Acadia, Calcasieu, Iberia, Lafayette, Rapides, St. Landry, St. Martin and Vermilion parishes

☐ **Blue Advantage (HMO) 010-2: $0 per month**
Includes Allen, Avoyelles, Beauregard, Cameron, Evangeline, Grant, Jefferson Davis, St. Mary and Vernon parishes

☐ **Blue Advantage (HMO) 011 with Part B Give Back: $0 per month**
Available statewide

☐ **Blue Advantage (PPO) 007: $0 per month**
Available statewide

☐ **Blue Advantage (PPO) 004: $100 per month**
Available statewide

PAYING YOUR PLAN PREMIUM

If you enroll in a zero premium plan - If we determined 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. You can pay by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check, Electronic Funds Transfer (EFT) from your bank, Credit card, Debit card, or check via mail. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by SSA. You will be responsible for paying this extra amount in addition to your monthly charges. You will either have the amount withheld from your SSA benefit check or be billed directly by Medicare or the RRB. DO NOT pay Blue Advantage the Part D-IRMAA. **If you enroll in a plan with a premium** - You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check, each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will 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 RRB. DO NOT pay Blue Advantage the Part D-IRMAA.

PAYING YOUR PLAN PREMIUM (CONTINUED)

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. 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. 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 will bill you for the amount that Medicare doesn't cover.

Please select a premium payment option.

☐ Receive a bill: ☐ Monthly ☐ Quarterly (prepay only) ☐ Annually (prepay only)

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a *VOIDED* check or provide the following:

Account holder name: _____

Bank routing number: _____

Bank account number: _____

Account type: ☐ Checking ☐ Savings

☐ Credit/Debit Card. Please provide the following information:

Type of Card: ☐ Visa ☐ Mastercard ☐ Discover

Name of account holder as it appears on card:

Account number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: __ __ / __ __ __ __
M M Y Y Y Y

☐ 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 or 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.)

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer.**

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS (CONTINUED)

2. What's your race? Select all that apply.

☐ American Indian or Alaska 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.**

3. **Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:** ☐ Spanish ☐ Braille ☐ Audio CD ☐ Large print

Please contact Blue Cross and Blue Shield of Louisiana/Blue Cross and Blue Shield of Louisiana HMO at 1-800-363-9152 if you need information in an accessible format or language other than what is listed above. Our phone lines are open 8 a.m. to 8 p.m., 7 days a week. TTY users should call 711.

4. Do you work? ☐ Yes ☐ No

   Does your spouse work? ☐ Yes ☐ No

5. 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 Blue Advantage (HMO) or Blue Advantage (PPO)? ☐ Yes ☐ No

   If "yes," please 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: _____

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)

   _____

7. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If "yes," please provide your Medicaid number:_____

STOP PLEASE READ THIS IMPORTANT INFORMATION STOP

If you currently have health coverage from an employer or union, joining Blue Advantage (HMO) or Blue Advantage (PPO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this 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.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD (CONTINUED)

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 am leaving employer or union 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 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 a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Blue Advantage at 1-800-363-9152 (TTY users should call 711) to see if you are eligible to enroll. Our phone lines are open 7 days a week from 8 a.m. to 8 p.m.

PLEASE CHOOSE A PRIMARY CARE PROVIDER

Primary Care Provider (PCP):	PCP # from Provider Directory:	Is this your current provider?
Dr. _____ (First Name) (Last Name)		☐ Yes ☐ No

PLEASE READ AND SIGN BELOW (CONTINUED)

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

Blue Advantage (HMO) and Blue Advantage (PPO) are Medicare Advantage plans and have contracts with the Federal government. I will need to keep my Medicare Parts A and B. I must continue to pay my Medicare Part B premium. 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 is 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 Advantage (HMO) or Blue Advantage (PPO) serves a specific service area. If I move out of the area the plan 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, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.I understand that beginning on the date Blue Advantage (HMO) coverage begins, I must get all of my health care from Blue Advantage (HMO), except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date Blue Advantage (PPO) coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Blue Advantage (PPO) provides refunds for all covered benefits, even if I get services out of network. Services authorized by Blue Advantage (HMO) or Blue Advantage (PPO) and other services contained in my Blue Advantage (HMO) or Blue Advantage (PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Blue Advantage (HMO) or Blue Advantage (PPO) WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Cross and Blue Shield of Louisiana/Blue Cross and Blue Shield of Louisiana HMO, he/she may be paid based on my enrollment in a plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Blue Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that Blue Advantage 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 my behalf under the laws of the State where I live) 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 from Blue Advantage or by Medicare.

Signature:	**Today's Date:**

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

Name:	Relationship to Enrollee:	Phone Number: ( )	
Address:	City:	State:	ZIP:

FOR OFFICE USE ONLY		
Name of Sales Rep/Agent/Broker (if assisted in enrollment):	**Agent NPN#:**	**Application Receipt Date:**
Plan ID#:	**Effective Date of Coverage:**	

Election Periods:

☐ **AEP** ☐ **ICEP** ☐ **IEP for Part D** ☐ **OEP** ☐ **MADP** ☐ **OEPI** ☐ **IEP2**

Special Election Periods SEP:

- ☐ LOC
- ☐ Non-renew/TERM
- ☐ GROUP RETIREE/LEC
- ☐ NON
- ☐ DUAL ELIGIBLE
- ☐ OTHER LOSS DUAL ELIGIBLE
- ☐ CHRONIC SNP NON-ELIGIBILITY
- ☐ SPAP
- ☐ LOSS OF SPAP
- ☐ LIS
- ☐ LOSS OF LIS
- ☐ CHRONIC SNP
- ☐ DST
- ☐ SEP

Please return completed application to:

Blue Cross and Blue Shield of Louisiana/Blue Cross and Blue Shield of Louisiana HMO
130 DeSiard Street, Suite 322, Monroe, LA 71201-7319
Fax: 1-877-553-6152

Please call 1-800-363-9152 for more information, including free language translation services, regarding your Blue Advantage (HMO) or Blue Advantage (PPO) plan. TTY users call the national relay service toll free at 711. Our telephone lines are open 7 days a week from 8 a.m. to 8 p.m. You may receive a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day.

Out-of-network/non-contracted providers are under no obligation to treat Blue Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

READY TO ENROLL? Choose which option works for you.

CALL

Call us at 1-800-232-4967 (TTY 711), 8 a.m. to 8 p.m., 7 days a week. Licensed agents are available.

ONLINE

Visit www.bcbsla.com/blueadvantage and choose Enroll Now.

FAX

Fax this completed enrollment form to 1-877-553-6152.

MAIL

Complete this enrollment form, place it in a stamped and addressed envelope, then mail it to:

Blue Cross and Blue Shield of Louisiana/HMO Louisiana Inc.
130 DeSiard Street, Suite 322
Monroe, LA 71201-7319