



INDIVIDUAL ENROLLMENT FORM
Medical and Prescription Drug Coverage

Do not send a payment with this application. You will be billed at a later date.

Sec. I To enroll in Medicare Plus Blue, please provide the following information:

Check which option you want to enroll in: (See premium table on other side of this form.)

Region (See counties on Premium Table)	Option A	Option B	Option C	Option D
Region 1: Southwest Michigan	<input type="checkbox"/> \$ 0	<input type="checkbox"/> \$47	<input type="checkbox"/> \$57	<input type="checkbox"/> \$114
Region 2: Mid-Michigan	<input type="checkbox"/> \$ 0	<input type="checkbox"/> \$73	<input type="checkbox"/> \$85	<input type="checkbox"/> \$141
Region 3: Upper Michigan	<input type="checkbox"/> \$54	<input type="checkbox"/> \$98	<input type="checkbox"/> \$111	<input type="checkbox"/> \$162
Region 4: South Michigan	<input type="checkbox"/> \$38	<input type="checkbox"/> \$98	<input type="checkbox"/> \$111	<input type="checkbox"/> \$177
Region 5: North/East Michigan	<input type="checkbox"/> \$60	<input type="checkbox"/> \$118	<input type="checkbox"/> \$130	<input type="checkbox"/> \$198
Region 6: Southeast Michigan	<input type="checkbox"/> \$59	<input type="checkbox"/> \$140	<input type="checkbox"/> \$151	<input type="checkbox"/> \$239

The person that is discussing plan options with you is either employed by or contracted with Blue Cross Blue Shield of Michigan (BCBSM). The person may be compensated based on your enrollment in a plan.

Last Name _____ First Name _____ Middle Initial _____
 Mr. Mrs. Ms.

Birth Date (/ /) _____ Sex Male Female
 Social Security Number (Optional) _____ Home Phone Number () _____

Permanent Residence Street Address _____ County _____

City _____ State _____ Zip Code _____

Mailing Address (Only if different from your permanent residence street address)

Street Address _____ City _____ State _____ Zip Code _____

OPTIONAL INFORMATION

Alternate Contact (Person not living with you) _____
 Phone Number () _____ Relationship to You _____

Sec. II 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 the Social Security Administration or Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Claim Number _____ Sex M F

Is Entitled To: _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Sec. III

Your plan premium option:

Please select a payment option for your monthly premium. Check **only one** box.

- 1)** I would like to receive a monthly statement and pay directly by mail.
- 2)** I would like to have my premium automatically deducted from my bank account. Complete and return the "Authorization Agreement for Automatic Withdrawal" form. If you do not send in the authorization form, you will be placed in Option 1. (You will not receive a monthly bill if you choose this option.)

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

- 3)** Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Sec. IV Please answer the following questions to help Medicare coordinate your benefits.

1. 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.

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

2. Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Veterans Administration benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Medicare Plus Blue? Yes No
If "Yes", please list your other coverage and your identification number(s) for this coverage:

Name of other coverage: _____ ID No. for this coverage: _____ Group No. for this coverage: _____

3. 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: _____ Phone No. () _____

Address of the Institution: _____

City _____ State _____ Zip _____

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

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at www.bcbsm.com/ma.



Sec. V Please read this important information.

If you currently have health coverage from an employer or union, joining Medicare Plus Blue could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Medicare Plus Blue 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 whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Sec. VI Please read and sign below.

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

Medicare Plus Blue is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Medicare Plus Blue of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue Cross Blue Shield of Michigan-Medicare Plus Blue or by calling 1-800-MEDICARE TTY users should call 1-877-486-2048; 24 hours a day, 7 days a week.

Medicare Plus Blue serves a specific service area. If I move out of the area that Medicare Plus Blue 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, 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 when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage health plan. I understand that medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico.

Release of Information:

By joining Medicare Plus Blue, I acknowledge that Medicare Plus Blue 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 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 in which I reside), 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 or by Medicare.

Your Signature	Today's Date (Must mail within 30 days)
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Check here if you signed as the authorized representative.

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

Name _____ Phone Number (____) _____

Address _____ City _____ State _____ Zip _____

Relationship to Enrollee _____

Please mail this form to: Medicare Plus Blue
PO Box 440
Southfield, MI 48037

If you have questions about Medicare Plus Blue, call our Pre-enrollment Services Department at 1-800-485-4415, 7 days a week, from 8 a.m. to 8 p.m. EST. TTY users may call 1-800-481-8704. This document is available in alternative formats.

Information to determine enrollment periods

Typically you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements and check the box to the left of the statement(s), and we will contact you if we need additional information.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan. Date of move: __ / __ / ____
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I live in a Long Term Care Facility (for example, a nursing home or a long-term care facility).
Effective Date: __ / __ / ____
- I recently moved "out" of a Long Term Care Facility (for example, a nursing home or long term care facility). Effective Date: __ / __ / ____
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
Date of loss: __ / __ / ____
- I am either losing coverage I had from an employer or union or leaving employer or union coverage. Date of loss: __ / __ / ____
- I belong to a pharmacy assistance program provided by the state.
- I recently returned to the United States after living permanently outside the U.S.
Date of return: __ / __ / ____
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
Effective date: __ / __ / ____
- I am enrolled in the Original Medicare Plan.

If none of these statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll at: 1-800-485-4415, 7 days a week, from 8 a.m. to 8 p.m. EST. TTY users may call 1-800-481-8704.

Agent/Office Use Only: (Applicant does not need to complete this section).

Note to Agents: 2008 paper enrollment forms must be keyed into www.bcbsm.com/enrollmedicare or submitted to the Managing Agent or General Agent within 1 business day of accepting the paper enrollment form.

Date Producing Agent accepted enrollment form from Medicare Eligible: / /

Date Managing Agent or General Agent or Association received enrollment form from Producing Agent: / /

Name of Managing Agent or General Agent or Association (**print**): _____

Name of Producing Agent (**print** first name/last name): _____

Signature of Producing Agent: _____

2-digit Managing Agent or General Agent or Association Code:

5-digit Producing Agent Code:

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

Name of the BCBSM employee (**print** first name, last name): _____

BCBSM Badge #: **E** BCBSM Source Code:

Medicare Plus Blue Premium Table

The premiums vary by the county in which you permanently reside
(Rates are based on the use and cost of health care services in each region)

1. **Locate the region and county in which you permanently reside.**
2. **Look at the plan options to find your monthly premium rate.**
3. **Check the correct option box on the first page of this application.**
(Only one box may be checked.)

Medical and Prescription Drug Coverage	Premium rate per month Medicare Plus Blue			
Region with counties	Option A	Option B	Option C	Option D
Region 1: Southwest Michigan Allegan, Kent Ottawa, Muskegon, Newaygo	\$0	\$47	\$57	\$114
Region 2: Mid-Michigan Barry, Berrien, Cass, Clinton, Eaton, Ingham, Ionia, Kalamazoo, Van Buren	\$0	\$73	\$85	\$141
Region 3: Upper Michigan Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iron, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Marquette, Menominee, Montmorency, Ontonagon, Oscoda, Otsego, Presque Isle, Schoolcraft	\$54	\$98	\$111	\$162
Region 4: South Michigan Branch, Calhoun, Hillsdale, Jackson, Lenawee, Livingston, Monroe, St Joseph, Washtenaw	\$38	\$98	\$111	\$177
Region 5: North/East Michigan Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Iosco, Isabella, Lake, Lapeer, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Oceana, Ogemaw, Osceola, Roscommon, Saginaw, Saint Clair, Sanilac, Shiawassee, Tuscola, Wexford	\$60	\$118	\$130	\$198
Region 6: Southeast Michigan Macomb, Oakland, Wayne	\$59	\$140	\$151	\$239