



Blue Cross  
Blue Shield  
of Michigan

**INDIVIDUAL ENROLLMENT FORM**  
**Medical and Prescription Drug Coverage**  
**(Coverage Effective 2009)**

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"/> \$49	<input type="checkbox"/> \$94	<input type="checkbox"/> \$162
Region 2: Mid-Michigan	<input type="checkbox"/> \$ 0	<input type="checkbox"/> \$69	<input type="checkbox"/> \$117	<input type="checkbox"/> \$186
Region 3: Upper Michigan	<input type="checkbox"/> \$47	<input type="checkbox"/> \$103	<input type="checkbox"/> \$148	<input type="checkbox"/> \$208
Region 4: South Michigan	<input type="checkbox"/> \$35	<input type="checkbox"/> \$109	<input type="checkbox"/> \$156	<input type="checkbox"/> \$238
Region 5: North/East Michigan	<input type="checkbox"/> \$53	<input type="checkbox"/> \$130	<input type="checkbox"/> \$180	<input type="checkbox"/> \$275
Region 6: Southeast Michigan	<input type="checkbox"/> \$62	<input type="checkbox"/> \$142	<input type="checkbox"/> \$190	<input type="checkbox"/> \$297

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Mr.  Mrs.  Ms.

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

E-mail Address \_\_\_\_\_ Permanent Residence Street Address (No P.O. Box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

**Mailing Address** (Only if different from your permanent residence street address)  
 Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**OPTIONAL INFORMATION**

**Emergency Contact** \_\_\_\_\_  
 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)** \_\_\_\_\_

**Paying your plan premium**

You can pay your monthly plan premium by mail or automatic withdrawal from your bank account each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month. 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 does not cover.

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 each month. 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.
- 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.)

**Please read and answer the following important questions**

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 drug 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. Do you or your spouse work?  Yes  No

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  Braille only

Please contact Medicare Plus Blue at 1-800-485-4415 (TTY users should call 1-800-481-8704) if you need information in another format or language than what is listed above. Our office hours are 7 days a week, from 8 AM to 8 PM EST.



**Please read this important information.**

Medicare Plus Blue, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement 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, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at [www.bcbsm.com/ma](http://www.bcbsm.com/ma).

Once Medicare Plus Blue has received your enrollment form, you will receive a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in Medicare Plus Blue. If Medicare Plus Blue is not able to reach you by telephone, then you will receive a letter by mail that contains similar 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.

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

Medicare Plus Blue is a Private-Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can only be in one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or 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. 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 - December 31 of every year), or under certain special circumstances.

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

Before seeing a provider, I should verify that the provider will accept Medicare Plus Blue. 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, I will need to find another provider that will.

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 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, he/she may be compensated based on my enrollment in Medicare Plus Blue.

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 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 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 or by Medicare.

**Your Signature**

**Today's Date**

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

## 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 also join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 recently moved outside of the service area for my current plan. Date of Move: \_\_/\_\_/\_\_\_\_
- I recently moved and this plan is a new option for me. 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 am no longer eligible for extra help paying for my Medicare prescription drugs.  
Effective Date: \_\_/\_\_/\_\_\_\_
- I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or a long-term care facility). Effective Date: \_\_/\_\_/\_\_\_\_
- I recently "left" a PACE program. Date: \_\_/\_\_/\_\_\_\_
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).  
Date of Loss: \_\_/\_\_/\_\_\_\_
- I am leaving employer or union coverage. Effective Date: \_\_/\_\_/\_\_\_\_
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.  
Date of Return: \_\_/\_\_/\_\_\_\_
- In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan for the first time (\*Medicare Advantage plan with prescription drug coverage).
- In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
- I am currently receiving extra help paying for Medicare prescription drug coverage but do not have Medicaid.
- I am eligible to join or leave a Medicare Advantage Plan. Note: Open Enrollment Period only  
Effective Date: \_\_/\_\_/\_\_\_\_
- My plan is ending its contract with Medicare.
- I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
- I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.
- I received a notice from my plan or Medicare telling me that I am eligible for a Special Enrollment Period.
- None of these statements applies to me.\*

\* Please contact Medicare Plus Blue at 1-800-485-4415 (TTY users should call 1-800-481-8704) to see if you are eligible to enroll. We are open 7 days a week, from 8 AM to 8 PM EST.

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

**Note to Agents:** 2009 paper enrollment forms must be keyed into [www.bcbsm.com/enrollmedicare](http://www.bcbsm.com/enrollmedicare) or submitted to the Managing or General Agent within 24 hours of accepting the paper enrollment form.

**Date Producing Agent accepted paper enrollment from Medicare Eligible:**   /   /

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

Name of Managing or General Agent or Association (print): \_\_\_\_\_

Name of Producing Agent (print first, last name): \_\_\_\_\_

Signature of Producing Agent: \_\_\_\_\_

**2-digit Managing 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 person entering enrollment information online (print first, 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.)

<b>Medical and Prescription Drug Coverage</b>	<b>Premium rate per month Medicare Plus Blue</b>			
<b>Region with counties</b>	<b>Option A</b>	<b>Option B</b>	<b>Option C</b>	<b>Option D</b>
<b>Region 1: Southwest Michigan</b> Allegan, Kent Ottawa, Muskegon, Newaygo	<b>\$0</b>	<b>\$49</b>	<b>\$94</b>	<b>\$162</b>
<b>Region 2: Mid-Michigan</b> Barry, Berrien, Cass, Clinton, Eaton, Ingham, Ionia, Kalamazoo, Van Buren	<b>\$0</b>	<b>\$69</b>	<b>\$117</b>	<b>\$186</b>
<b>Region 3: Upper Michigan</b> 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	<b>\$47</b>	<b>\$103</b>	<b>\$148</b>	<b>\$208</b>
<b>Region 4: South Michigan</b> Branch, Calhoun, Hillsdale, Jackson, Lenawee, Livingston, Monroe, St Joseph, Washtenaw	<b>\$35</b>	<b>\$109</b>	<b>\$156</b>	<b>\$238</b>
<b>Region 5: North/East Michigan</b> Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Assoc., Isabella, Lake, Lapeer, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Oceana, Ogemaw, Osceola, Roscommon, Saginaw, Saint Clair, Sanilac, Shiawassee, Tuscola, Wexford	<b>\$53</b>	<b>\$130</b>	<b>\$180</b>	<b>\$275</b>
<b>Region 6: Southeast Michigan</b> Macomb, Oakland, Wayne	<b>\$62</b>	<b>\$142</b>	<b>\$190</b>	<b>\$297</b>