



South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association

2010 Private Fee-for-Service Individual Enrollment Request Form

P.O. Box 100191, Columbia, SC 29202-3191

Please contact Medicare Blue Private (PFFS) if you need information in another language or format (Braille).

To Enroll in Medicare BlueSM Private (PFFS), Please Provide the Following Information:

LAST name:	FIRST name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (__ __/ __ __/ __ __ __ __) (M M/D D/Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone Number: (optional) ()
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency contact: _____ **Relationship to You:** _____

Phone Number: _____


E-mail Address: _____

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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan such as Medicare Blue Private (PFFS).

Medicare		Health Insurance
SAMPLE ONLY		
Name: _____		
Medicare Claim Number		Sex _____
_____ - _____ - _____ - _____		
Is Entitled To		Effective Date
HOSPITAL (Part A)		_____
MEDICAL (Part B)		_____

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Order # 12492M

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Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No

If you answered “yes” to this question and you don’t need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing that you don’t need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? Yes No

Please check one of these boxes if you would prefer that we send you information in a language other than English or in another format: Spanish Large print or audio tape

Please contact Medicare Blue Private (PFFS) at 1-888-645-6025 if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week, from November 15, 2009 through March 1, 2010; beginning March 2, 2010, your calls will be handled by our automated phone system after 8:00 p.m. and on Saturdays, Sundays and holidays. TTY users should call 1-888-645-6023.



Please Read This Important Information

Medicare Blue Private (PFFS), a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn’t required to agree to accept our plan’s terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept Medicare Blue Private (PFFS) before each visit. Providers can find the plan’s terms and conditions on our website at www.SouthCarolinaBlues.com/pffs10/tnc.

Once Medicare Blue Private (PFFS) has your enrollment form, you will get 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 Blue Private (PFFS). If Medicare Blue Private (PFFS) isn’t able to reach you by telephone, then you will get a letter by mail that contains similar information.

Please Read and Sign Below:

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

Medicare Blue Private (PFFS) is a Medicare Private Fee-for-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and I can be in only 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that since this plan does not offer Medicare prescription drug coverage, or creditable prescription drug coverage, I may get coverage from another Medicare prescription drug plan. If I don’t 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 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 Blue Private (PFFS) works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Medicare Blue Private (PFFS) pays instead of Medicare, and I will be responsible for the amounts that Medicare Blue Private (PFFS) doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in Medicare Blue Private (PFFS).

Before seeing a provider, I should verify that the provider will accept Medicare Blue Private (PFFS). I understand that my health care providers have the right to choose whether to accept Medicare Blue Private (PFFS)'s payment terms and conditions every time I see them. I understand that if my provider doesn't accept Medicare Blue Private (PFFS), I will need to find another provider that will.

Medicare Blue Private (PFFS) serves a specific service area. If I move out of the area that Medicare Blue Private (PFFS) serves, I need to notify Medicare Blue Private (PFFS) so I can disenroll and find a new plan in my new area. Once I am a member of Medicare Blue Private (PFFS), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook or Evidence of Coverage document from Medicare Blue Private (PFFS) when I get it, to know which rules I must follow to get coverage with this Private Fee-for-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medicare Blue Private (PFFS), he/she may be paid based on my enrollment in Medicare Blue Private (PFFS).

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 Blue Private (PFFS) will release my information 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) 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 Blue Private (PFFS) 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: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Agent Name (*print*): _____ Agent Number: _____

Agent Signature: _____ Date: _____

Attestation of Eligibility for an Enrollment Period

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 the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage. (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare 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 or I recently moved and this plan is a new option for me. I moved on *(insert date)* _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on *(insert date)* _____.
- 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 recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on *(insert date)* _____.
- I am leaving employer or union coverage on *(insert 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. I returned to the U.S. on *(insert date)* _____.
- None of these statements applies to me.*

*Please contact Medicare Blue Private (PFFS) at 1-800-760-1790 (TTY users should call 1-888-899-4219) to see if you are eligible to enroll. We are open seven days a week, from 8:00 a.m. to 8:00 p.m. Eastern Time, from November 15, 2009 through March 1, 2010; beginning March 2, 2010, your calls will be handled by our automated phone system after 8:00 p.m. and on Saturdays, Sundays and holidays.