OMB No. 0938-1378
Expires:7/31/2023

South Carolina
Medicare Advantage

2022 BlueCross Total℠ Value (PPO) Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 - December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account, credit/debit card or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
BlueCross Total Value
P.O Box 100191
Columbia, SC 29202

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call BlueCross Total Value at 1-855-204-2744. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a BlueCross Total Value al 1-855-204-2744/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

_____ BlueCross Total Value (Upstate) - $0.00 per month
_____ BlueCross Total Value (Midlands/Coastal) - $0.00 per month
_____ BlueCross Total Value (Lowcountry) - $0.00 per month

FIRST name:_____

LAST name:_____ (Optional) Middle Initial:_____

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __) Sex: ____ Male ____Female

Phone number: (__ __ __) __ __ __ - __ __ __ __

Permanent Residence street address
(Don't enter a PO Box):_____

City:_____ State:_____ ZIP Code:_____

Mailing address, if different from your permanent address (PO Box allowed):

Street address:_____

City:_____ State:_____ ZIP Code:_____

Emergency Contact: _____

Phone Number: (__ __ __) __ __ __ - __ __ __ __ Relationship to You: _____

E-mail Address: (optional)

_____

Your Medicare 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 (MM/DD/YYYY):
HOSPITAL (Part A)	__ __ / __ __ / __ __ __ __
MEDICAL (Part B)	__ __ / __ __ / __ __ __ __

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

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Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueCross Total Value?

_____ Yes _____ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

IMPORTANT: Read and sign below:

• I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueCross Total Value.
• By joining this Medicare Advantage Plan, I acknowledge that BlueCross Total Value will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
• Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
• 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
• I understand that when my BlueCross Total Value coverage begins, I must get all of my medical and prescription drug benefits from BlueCross Total Value. Benefits and services provided by BlueCross Total Value and contained in my BlueCross Total Value "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueCross Total Value will pay for benefits or services that are not covered.
• I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Signature:_____ **Today's date:**_____

If you're the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

_____

Phone number: (__ __ __) __ __ __ - __ __ __ __ Relationship to enrollee: _____

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Agent Use Only:

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____

BlueCross BlueShield of SC MAPD Agent ID: _____

Agent Name: _____

Date: _____

Agents must submit a signed enrollment form within 24 hours of receipt.

Section 2 – All fields on this page are optional

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

Select one if you want us to send you information in a language other than English.

Spanish ____ Other ____

Select one if you want us to send you information in an accessible format.

___ Braille ___ Large Print ___ Audio CD

Please contact BlueCross at 1-855-204-2744 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., Eastern Time, Monday - Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1, through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.

Do you work? ___ Yes ___ No Does your spouse work? ___Yes ___No

List your Primary Care Physician (PCP), clinic, or health center:

_____

I want to get the following materials via email. Select one or more.

___ Evidence of Coverage ___ Pharmacy/Provider Directories ___ Formulary

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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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.

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 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.

☐ 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 BlueCross at 1-855-204-2744, TTY users should call 711. Our office hours are 8 a.m. to 8 p.m., Eastern Time, Monday - Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1, through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.