OMB No. 0938-1378
Expires:7/31/2024

2024 BlueCross Rx Essential℠/Rx Value℠/Rx Plus℠ (PDP) Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan.

To join a plan, you must:

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

Important: To join a Medicare Prescription Drug Plan, you must also have either, or 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 January1)
- 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 Rx
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 Rx at 1-888-645-6025. 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 Rx al 1-888-645-4227/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.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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

Select the plan you want to join:

_____ BlueCross Rx Essential - $77.00 per month
_____ BlueCross Rx Value - $117.40 per month
_____ BlueCross Rx Plus - $157.40 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/or Part B to join a Medicare Prescription Drug Plan.

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Answer these important questions:

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

_____ 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/or Medical (Part B) to stay in BlueCross Rx.
- By joining this Medicare Prescription Drug Plan, I acknowledge that BlueCross Rx 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 thecountry, except for limited coverage near the U.S. border.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) onthis 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: _____

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.

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

___No, not of Hispanic, Latino/a, or Spanish origin
___Yes, Puerto Rican
___Yes, another Hispanic, Latino/a, or Spanish origin
___Yes, Mexican, Mexican American, Chicano/a
___Yes, Cuban
___**I choose not to answer**.

What's your race? Select all that apply.

___American Indian or Alaska Native
Asian:
- ___Asian Indian
- ___Chinese
- ___Filipino
- ___Japanese
- ___Korean
- ___Vietnamese
- ___Other Asian

___Black or African American
Native American and Pacific Islander:
- ___Guamanian of Chamorro
- ___Native Hawaiian
- ___Samoan
- ___Other Pacific Islander

___White
___**I choose not to answer.**

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.**

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 1-888-645-6025 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 Directories ___ Formulary

Paying your plan premiums

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 having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay BlueCross the Part D-IRMAA.

Please select a premium payment option:

☐ Get a bill.

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

Account holder name:_____

Bank routing number: _____

Bank account number: _____

☐ Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: _____

Expiration Date (MM/YYYY):_____/ _____

Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/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.)

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 anew 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 affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact BlueCross at 1-888-645-6025, 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.