

# 2025 BlueCross Total Value<sup>SM</sup> (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](https://www.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.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

### IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

## 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 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 8 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.

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

### Select the plan you want to join:

\_\_\_ BlueCross Total Value Upstate - \$0 per month

\_\_\_ BlueCross Total Value Midlands - \$0 per month

\_\_\_ BlueCross Total Value Lowcountry - \$0 per month

FIRST name:

LAST name:

Middle Initial:

Birth date: (MM/DD/YYYY)

(   /   /   )

Sex:

Male  Female

Phone number:

(   )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

County:

State:

ZIP Code:

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

Street address:

City:

State:

ZIP Code:

### Your Medicare information:

Medicare Number:

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### 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, 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.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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 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:

## Section 2 – All fields in this section 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, Mexican, Mexican American, Chicano/a  
 Yes, Puerto Rican       Yes, Cuban  
 Yes, another Hispanic, Latino/a, or Spanish origin  
 **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 Hawaiian and Pacific Islander:  
 Guamanian or Chamorro  
 Native Hawaiian  
 Samoan  
 Other Pacific Islander  
 White  
 **I choose not to answer.**

What is your gender? Select one.

- Woman       I use a different term: \_\_\_\_\_  
 Man       **I choose not to answer**  
 Non-binary

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay       I use a different term: \_\_\_\_\_  
 Straight, that is, not gay or lesbian       I don't know  
 Bisexual       **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     Data CD

Please contact BlueCross Total Value at 1-855-204-2744 if you need information in an accessible format other than what's listed above. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time. All other times, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time. TTY users can call 711.

Do you work?     Yes     No

Does your spouse work?     Yes     No

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

**For individuals helping enrollee with completing this form only**

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_

Signature: \_\_\_\_\_

National Producer Number (Agents/Brokers only): \_\_\_\_\_

BBSSC MA Agent ID: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_

Date: \_\_\_\_\_

**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 of the Social Security Act and 42 CFR §§ 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.