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

Capital

Medicare Advantage Individual Enrollment 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.
    - To enroll in Capital Blue Cross | WellSpan Health PPO/HMO, you must reside in one of these counties in Pennsylvania: Adams, Cumberland, Franklin, Lancaster, Lebanon, or York.
    - To enroll in BlueJourney PPO or BlueJourney HMO, you must reside in one of these counties in Pennsylvania: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, or York.

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 three 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 or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Medicare Programs
PO Box 779827
Harrisburg, PA 17177-9827

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

How do I get help with this form?

Call Capital Blue Cross at 800.990.4201 (TTY: 711).

Or, call Medicare at 800.MEDICARE (800.633.4227). TTY users can call 877.486.2048.

En español: Llame a Capital Blue Cross al 800.990.4201 (TTY: 711) o a Medicare gratis al 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)

Please print.
Please check which plan you want to enroll in:

- ☐ Capital Blue Cross | WellSpan Health **Advantage** PPO
- ☐ Capital Blue Cross | WellSpan Health **AdvantagePlus** PPO
- ☐ Capital Blue Cross | WellSpan Health **Inspire** HMO

- ☐ BlueJourney **Select** PPO
- ☐ BlueJourney **Classic** PPO
- ☐ BlueJourney **Prime** PPO
- ☐ BlueJourney **Essential** HMO
- ☐ BlueJourney **Value** HMO
- ☐ BlueJourney **Premier** HMO

***You must live in the service area for your chosen plan as specified on page 1.**

Last Name:		First Name:		Middle Initial:	
Birth Date: (MM/DD/YYYY)	__ __/__ __/__ __ __ __	Sex: ☐ Male ☐ Female		Phone Number:	(__ __ __) __ __ __-__ __ __ __
Permanent Residence Street Address: (Do not enter a PO Box):					
City:		County:		State:	ZIP Code:
Mailing Street Address (if different from your permanent address, PO Box allowed):					
City:		State:		ZIP Code:	
Email Address:					

Your Medicare Information:

Medicare Number:	____ ____ ____ ____-____ ___ ____-____ ____ ____ ____		
HOSPITAL (Part A) Effective Date:	__ __/__ __/__ __ __ __	MEDICAL (Part B) Effective Date:	__ __/__ __/__ __ __ ___

Answer these important questions:

Will you have other prescription drug coverage (e.g., VA, TRICARE) in addition to your new Capital Blue Cross Medicare Advantage plan?

☐ Yes ☐ No

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

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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.

Applicant Demographic Information (Answering is Optional)

Are you of Hispanic, Latino, or Spanish origin? Please check the appropriate box.

- ☐ **No**, not of Hispanic, Latino, or Spanish origin.
- ☐ **Yes**, Mexican, Mexican American, Chicano
- ☐ **Yes**, Puerto Rican
- ☐ **Yes**, Cuban
- ☐ **Yes**, other Hispanic, Latino, or Spanish origin

How would you best describe yourself? Please check the appropriate box.

- ☐ White
- ☐ Black, African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Other race

What is the primary language spoken in the home?

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ German
- ☐ French
- ☐ Other

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center below **(HMO applicants only)**

Practice Name:		PCP Number:	

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)" 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 Capital Blue Cross the Part D-IRMAA.

Select a premium payment option:

☐ Get a bill.

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

Account holder name: _____ Bank routing number: __ __ __ __ __ __ __ __ __

Bank account number: __ __ __ __ __ __ __ __ __ __ __ __ Account type: ☐ Checking ☐ Savings

To request automatic deductions from your Social Security or Railroad Retirement Board (RRB) benefit each month, please contact Member Services once you receive confirmation of your enrollment.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plan, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 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.

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IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in the Capital Blue Cross Medicare Advantage plan.
- By joining this Medicare Advantage plan, I acknowledge that Capital Blue Cross 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 on previous page).
- 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 Capital Blue Cross Medicare Advantage plan coverage begins, I must get all of my medical and prescription drug benefits from the Capital Blue Cross Medicare Advantage plan. Benefits and services provided by the Capital Blue Cross Medicare Advantage plan and contained in my Capital Blue Cross Medicare Advantage plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor the Capital Blue Cross Medicare Advantage plan will pay for benefits or services that are not covered.
- By providing a telephone number and/or an email address, I hereby authorize Capital Blue Cross, its affiliates, subsidiaries and/or agents (collectively "Capital Blue Cross") to communicate with me by phone, text messages, faxes, and/or emails for billing, transactional, informational, marketing, or any other purposes including, without limitation, calls or messages made or sent using an automatic telephone dialing system or artificial/prerecorded voice. I understand that I may opt out at any time.
- 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:		Phone Number:	
Street Address:		Relationship to enrollee:	
City:		State:	ZIP Code:

Sales Agent Information: ☐ Appointment ☐ Seminar ☐ Date of Seminar (MM/DD/YYYY): __ __/__ __/__ __ __ __

Name of staff member/agent/broker (if assisted in enrollment):	Agent/broker NPN:
Date agent/broker received application (MM/DD/YYYY): __ __/ __ __/ __ __ __ __	Effective date of coverage (MM/DD/YYYY): __ __/ __ __/ __ __ __ __

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 (MM/DD/YYYY) _____.

☐ I recently was released from incarceration. I was released on (MM/DD/YYYY) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (MM/DD/YYYY) _____.

☐ I recently obtained lawful presence in the United States. I got this status on (MM/DD/YYYY) _____.

☐ I recently had a change in my Medicaid, (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (MM/DD/YYYY) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (MM/DD/YYYY) _____.

☐ 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 (MM/DD/YYYY) _____.

☐ I recently left a PACE program on (MM/DD/YYYY) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (MM/DD/YYYY) _____.

☐ I am leaving employer or union coverage on (MM/DD/YYYY) _____.

☐ 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 (MM/DD/YYYY) _____.

☐ 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 (MM/DD/YYY) _____.

☐ 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 because of the disaster.

If none of these statements applies to you or you're not sure, please contact us at 800.990.4201 (TTY: 711) to see if you are eligible to enroll. We are open 8 a.m. to 6 p.m. Monday through Friday, with extended hours from October 15 to December 7 of 8 a.m. to 8 p.m., Sunday through Saturday.

Desired Effective Date (restrictions apply) (MM/DD/YYYY) _____.