

*Please contact BlueJourney Alliance Assisted Care (HMO SNP) if you need information in another language or format (Braille).*

**BlueJourney Alliance Assisted Care (HMO SNP) is a Medicare Advantage Special Needs Plan that offers coverage for individuals that require an institutional level of care.**

An institutional level-of-care can be provided by a skilled nursing facility (SNF), nursing facility (NF), SNF/NF, intermediate care facility for the mentally retarded (ICF/MR), or inpatient psychiatric facility. This care can also be provided outside of a facility but be considered institutionally-equivalent.

**Please review the below statements and answer the following questions:**

Do you require an institutional level-of-care?

Yes  No

Do you currently reside in a SNF, NF, SNF/NF, ICF/MR, or inpatient psychiatric facility?

Yes  No

If so, when did you start residing in this facility?

\_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_  
(MM/DD/YYYY)

Please provide the name, address, and phone number for this facility in the fields below:

Name:

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number:

(       )

If you have not resided in a facility for at least 90 days, a representative of BlueJourney Alliance Assisted Care (HMO SNP) will contact you to schedule a level-of-care assessment. This will assist us in determining whether you are eligible to join this plan. Please provide contact information that BlueJourney Alliance Assisted Care (HMO SNP) can use to schedule this appointment. This person can be a caregiver or other authorized representative.

Name:

Phone Number:

(       )



**To Enroll in BlueJourney Alliance (HMO SNP), Please Provide the Following Information:**

LAST Name:		FIRST Name:		Middle Initial:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date: (MM/DD/YYYY)	____ / ____ / ____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (        )			
Permanent Residence Street Address (P.O. Box is not allowed):							
City:			County:		State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):			Street Address:				
City:					State:	ZIP Code:	
Email Address:							

**Please Provide Your Medicare Insurance 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
<b>HOSPITAL (Part A)</b>	_____
<b>MEDICAL (Part B)</b>	_____

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

**Paying Your Plan Premium**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by “Electronic Funds Transfer” (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT** pay BlueJourney Alliance (HMO SNP) the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don’t even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover.

If you don’t select a payment option, you will get a bill each month.

**Paying Your Plan Premium (continued)**

**Please 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
- Automatic deduction from your monthly Social Security or 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.

**Please read and answer these important questions:**

**1. Do you have End-Stage Renal Disease (ESRD)?**  Yes  No  
 If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

**2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.**  
 Will you have other prescription drug coverage in addition to BlueJourney Alliance (HMO SNP)?  Yes  No  
 If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

2a. Name of other coverage:	2b. ID # for this coverage:	2c. Group # for this coverage:
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**3. Are you a resident in a long-term care facility, such as a nursing home?**  Yes  No  
 If "yes," please provide the following information:  
 Name of Institution: \_\_\_\_\_

3a. Facility Address:	3b. Phone Number: (     )
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**4. Are you enrolled in your State Medicaid program?**  Yes  No  
 If "yes," please provide your Medicaid number: \_\_\_\_\_

**5. Do you or your spouse work?**  Yes  No

**Primary Care Physician Selection:**

Practice Name:	PCP#:
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**Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:**  Audio Tape  Large Print  Spanish

Please contact BlueJourney Alliance (HMO SNP) at 1-800-990-4201 if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 a.m. to 6:00 p.m. Monday through Friday, with extended hours from October 15 to December 7 of 8:00 a.m. to 8:00 p.m., Sunday through Saturday. TTY users should call 711.



**Please Read This Important Information**

**If you currently have health coverage from an employer or union, joining BlueJourney Alliance (HMO SNP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueJourney Alliance (HMO SNP).** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Please Read and Sign Below**

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

BlueJourney Alliance (HMO SNP) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get 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 when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

BlueJourney Alliance(HMO-SNP) serves a specific service area. If I move out of the area that BlueJourney Alliance (HMO SNP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BlueJourney Alliance (HMO SNP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueJourney Alliance (HMO SNP) when I get it to know which rules I must follow to get coverage with this Medicare Advantage 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 beginning on the date BlueJourney Alliance (HMO SNP) coverage begins, I must get all of my health care from BlueJourney Alliance (HMO SNP), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BlueJourney Alliance (HMO SNP) and other services contained in my BlueJourney Alliance (HMO SNP) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUEJOURNEY ALLIANCE (HMO SNP) WILL PAY FOR THE SERVICES.**

By providing a telephone number and/or an email address, I hereby authorize Capital BlueCross, its affiliates, subsidiaries and/or agents (collectively "Capital BlueCross") 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BlueJourney Alliance (HMO SNP), he/she may be paid based on my enrollment in BlueJourney Alliance (HMO SNP).

**Release of Information:** By joining this Medicare health plan, I acknowledge that BlueJourney Alliance (HMO SNP) will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that BlueJourney Alliance (HMO SNP) will release my information, including my prescription drug event data, 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 from Medicare.

<b>Signature:</b>	<b>Today's Date:</b>
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If you are the authorized representative, you must sign above and provide the following information:

<b>Name:</b>	<b>Phone Number:</b> (      )	
<b>Street Address:</b>	<b>Relationship to enrollee:</b>	
<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b>

**Sales Agent Information:**

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) ____ / ____ / _____

**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 submitting my application during the Annual Election Period, which occurs from October 15 through December 7.
- 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/yyyy)\_\_\_\_\_.
- 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 us at 1-800-990-4201 to see if you are eligible to enroll. We are open 8:00 a.m. to 6:00 p.m. Monday through Friday, with extended hours from October 15 to December 7 of 8:00 a.m. to 8:00 p.m., Sunday through Saturday. TTY users should call 711.

Desired Effective Date (restrictions apply) (mm/dd/yyyy)\_\_\_\_\_.