



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.

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](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.

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), 24 hours a day/7 days a week. 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 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 address, 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.

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.

Capital Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association.

**Medicare Advantage
Individual Enrollment Form****Section 1—All fields on this page are required (unless marked optional)****Please print.**

Last name:		First name:		Middle initial:	
Birth date: (MM/DD/YYYY)	___/___/___	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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:	
Mailing street address (if different from your permanent address, PO Box allowed):					
City:		State:		ZIP Code:	
Email address: (Optional)					

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, state pharmaceutical assistance program, private insurance) 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:

List your Primary Care Physician (PCP), clinic, or health center below (optional)Tell us the name of your primary care physician (PCP) or their practice and their Capital group ID. If you don't provide this, we will assign one for you to assist with coordinating your care. Visit our online provider directory at [CapitalBlueMedicare.com](https://www.CapitalBlueMedicare.com) or call 800.990.4201 (TTY: 711) to find provider information or an in-network PCP.

PCP/Practice name:		Capital group ID:	
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Section 1 (continued)—All fields on this page are required (unless marked optional)

Plan selection: Please check which plan you want to enroll in.

Note:

- You must be a permanent resident of one of the counties noted next to each plan.
- All premium amounts listed are for coverage during 2025.

- ☐ Capital Blue Cross | WellSpan Health **Value** PPO
\$0 per month with \$28 Part B Premium Reduction.
- ☐ Capital Blue Cross | WellSpan Health **Advantage** PPO
\$0 per month.
- ☐ Capital Blue Cross | WellSpan Health **AdvantagePlus** PPO
\$26 per month.
- ☐ Capital Blue Cross | WellSpan Health **Complete** PPO
\$43 per month
- ☐ Capital Blue Cross | WellSpan Health **Inspire** HMO
\$0 per month with \$2 Part B Premium Reduction.

All Capital Blue Cross | WellSpan Health PPO/HMO plans serve residents of the following counties in Pennsylvania: Adams, Cumberland, Franklin, Fulton, Lancaster, Lebanon, or York.

- ☐ Capital Blue Cross **Value** PPO
\$0 per month with \$28 Part B Premium Reduction.
- ☐ Capital Blue Cross **Enhanced** PPO
\$27 per month for residents of Berks, Lehigh, Northampton, and Schuylkill counties.
- \$26 per month for residents of Centre, Columbia, Dauphin, Juniata, Mifflin, Montour, Northumberland, Perry, Snyder, and Union counties.
- ☐ Capital Blue Cross **Complete** PPO
\$43 per month.

Unless otherwise noted, all Capital Blue Cross PPO plans in this row serve residents of the following counties in Pennsylvania: Berks, Centre, Columbia, Dauphin, Juniata, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, or Union.

- ☐ Capital Blue Cross **Select** PPO
\$0 per month.
- ☐ Capital Blue Cross **Classic** PPO
\$66 per month.
- ☐ BlueJourney **Prime** PPO
\$168 per month.
- ☐ Capital Blue Cross **Essential** HMO
\$0 per month with \$2 Part B Premium Reduction.
- ☐ BlueJourney **Value** HMO
\$53 per month.
- ☐ BlueJourney **Premier** HMO
\$84 per month.

All Capital Blue Cross PPO/HMO and all BlueJourney PPO/HMO plans serve residents of the following counties in Pennsylvania: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.



Medicare Advantage Individual Enrollment Form

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

- | | |
|--|--|
| <input type="checkbox"/> No , not of Hispanic, Latino/a, or Spanish origin. | <input type="checkbox"/> Yes , Cuban. |
| <input type="checkbox"/> Yes , Mexican, Mexican American, Chicano/a. | <input type="checkbox"/> Yes , other Hispanic, Latino/a, or Spanish origin. |
| <input type="checkbox"/> Yes , Puerto Rican. | <input type="checkbox"/> I choose not to answer. |

What is your race? Select all that apply.

- | | | | | |
|--|---|---|--------------------------------------|---|
| <input type="checkbox"/> White. | <input type="checkbox"/> Asian Indian. | <input type="checkbox"/> Chinese. | <input type="checkbox"/> Filipino. | <input type="checkbox"/> Other Asian. |
| <input type="checkbox"/> Black, African American. | <input type="checkbox"/> Japanese. | <input type="checkbox"/> Korean. | <input type="checkbox"/> Vietnamese. | <input type="checkbox"/> Other Pacific Islander. |
| <input type="checkbox"/> American Indian or Alaska Native. | <input type="checkbox"/> Native Hawaiian. | <input type="checkbox"/> Guamanian or Chamorro. | <input type="checkbox"/> Samoan. | <input type="checkbox"/> I choose not to answer. |

What is the primary language spoken in the home?

- | | | |
|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> English. | <input type="checkbox"/> Chinese. | <input type="checkbox"/> French. |
| <input type="checkbox"/> Spanish. | <input type="checkbox"/> German. | <input type="checkbox"/> Other. |

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

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

- ☐ Braille. ☐ Large print. ☐ Audio CD. ☐ Data CD.

Please contact Member Services at 866.987.4213 (PPO members) or 800.779.6962 (HMO members) (TTY: 711) if you need information in another language or format. Our office hours are Monday through Sunday, 8:00 AM to 8:00 PM, October 1 through March 31 and Monday through Friday, 8:00 AM to 8:00 PM, April 1 through September 30.

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



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Section 2 (continued)—All fields on this page are optional

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)," on the web, or by phone 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. DON'T pay Capital Blue Cross the Part D-IRMAA.

Select a premium payment option:

☐ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

Account holder name: _____ Bank routing number: _____

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

☐ Get a bill.

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

I get monthly benefits from: ☐ Social Security ☐ RRB

Due to processing timeframes mandated by Medicare, your Social Security/RRB deduction may not begin with your first month's premium. If that occurs, Capital Blue Cross will issue you a bill for the initial payment and submit your request for Social Security/RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. If your request for automatic deduction is not approved, you will receive a monthly bill.

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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 below). My 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 to MA PFFS, MA MSA plans).
- 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.
- 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.
- 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:

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 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.



Medicare Advantage Individual Enrollment Form

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:		Signature:	
Agent/broker NPN (if applicable):		Relationship to enrollee:	<input type="checkbox"/> Agent <input type="checkbox"/> Broker <input type="checkbox"/> SHIP counselor <input type="checkbox"/> Other (third-party)
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 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 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 8:00 AM to 6:00 PM Monday through Friday, with extended hours from October 15 to December 7 of 8:00 AM to 8:00 PM, Sunday through Saturday.

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