# Basic Blue® Rx (PDP)

A Medicare Prescription Drug Plan

## 2019 Basic Blue® Rx (PDP) Individual Change Form

**Complete this form only if you wish to change your Basic Blue Rx plan option.**

**You qualify to change your plan option if you meet one of the following requirements:**

- It is during the annual enrollment period, October 15 to December 7
- You qualify for Extra Help with your prescription drug costs
- You no longer qualify for Extra Help
- You meet certain special exceptions (see the Enrollment Period Determination section on the next page)

**To change to a different Medicare Prescription Drug plan option with Basic Blue Rx:**

- Fill out the Change Form online at **BasicBlueRx.com**

or

- Fill out this form
- Check the plan option you want to change to
- Sign the form
- Mail the completed form to the address below

**Your coverage with the new plan option will be effective:**

- If we receive your completed form by the end of any month, your new benefit plan will generally begin the first of the following month.
- Selections made during the annual enrollment period (October 15 to December 7) are effective January 1.

**Questions?**

Visit us online at **BasicBlueRx.com**

Call Basic Blue Rx Customer Service: **1-877-376-2185**
(TTY hearing impaired users call **711**), 8 a.m. to 8 p.m., daily, local time

Write to Basic Blue Rx
P.O. Box 3566
Scranton, PA 18505

Contact your independent certified agent

# 2019 Basic Blue Rx individual change form

## A. Member information (please print clearly)

| Last Name: | First Name: | Middle Initial: |
|---|---|---|

| Member Number (Printed on your Basic Blue Rx ID card): | Medicare Number (Printed on your red, white and blue Medicare ID card): |
|---|---|

| Home Phone Number: | Alternate Phone Number (optional): | E-mail address (optional): |
|---|---|---|

Permanent Residence Street Address **(P.O. Box is not allowed)**:

| City: | State: | ZIP Code: |
|---|---|---|

## B. Plan options

I want to transfer from my current Part D plan to the Part D plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the first of the following month. Changes made during the Annual Enrollment Period are effective January 1 of the next year.

**Please check the box below for the plan option you wish to change to:**

Basic Blue Rx: ☐ Value ☐ Standard

## C. Enrollment period determination

**Typically, you may only enroll or change plan options in a Medicare Prescription Drug Plan during the annual enrollment period between October 15 and December 7.** Additionally, there are exceptions that may allow you to change your plan option in a Medicare Prescription Drug Plan outside of the annual enrollment 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. Your effective date will generally be the first of the month after your form is received by the plan.

☐ I am enrolling during the annual enrollment period, October 15 to December 7, for a **January 1, 2019 effective date.** (Note: The enrollment application must be received by December 7 for the enrollment to be effective on January 1.)

☐ 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 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 the level of Extra Help, or lost Extra Help) on (mm/dd/yyyy) _____.

☐ I 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) _____.

Enrollee name: _____

☐ 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 change because of the natural disaster.

☐ Other Special Enrollment Period not identified above _____

If none of the statements apply to you or if you are not sure, please contact Basic Blue Rx Customer Service using information on the front of this form to see if you are eligible to enroll.

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If you would prefer that we send you information in a language other than English or in an accessible format, please contact Basic Blue Rx Customer Service at the phone number on the front of this form.

## D. Paying your plan premium

For the 2019 calendar year, select a premium payment option:

☐ Keep my current premium payment option.

☐ Receive a paper bill. **Do not send a premium payment with this application.**

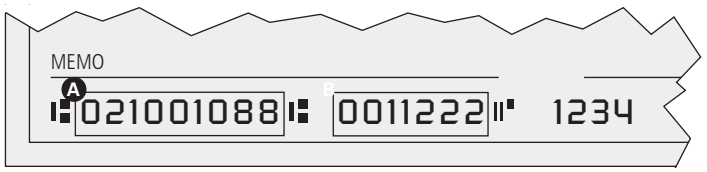
☐ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

Account holder name: _____

Financial institution: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ Checking ☐ Saving




Ⓐ The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.

Ⓑ Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

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

You can pay your monthly plan premium (including any late enrollment penalty) by mail or 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. You may also choose automatic deduction from your Social Security or RRB checks after you are enrolled. If Social Security/RRB does not approve your automatic deduction request, we will send you paper bills for your monthly premiums and resubmit your request. Once approved, it can take two or more months for the deduction to begin. During this time, you will receive paper bills and be responsible for paying your premium directly to the plan until the deduction begins. If you do not pay your premium for the months before the deduction takes effect, you may be disenrolled from the plan. Neither Social Security nor RRB allow retroactive withholding requests.

Enrollee name: _____

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 or RRB benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Basic Blue Rx.

It may take up to two months to process your Electronic Funds Transfer (EFT) request. Please pay your premiums billed to you on paper until your EFT is active. Any unpaid premiums due when EFT takes effect will be deducted at that time to bring your account up to date.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a 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**, 7 a.m. to 7 p.m., Monday - Friday. TTY users should call **1-800-325-0778**. You can also apply for Extra Help online at **ssa.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 receive a bill each month.

## E. Enrollment authorization: By completing this enrollment application, I agree to the following:

**After carefully reading all statements in this section, please sign Section F of this form. Keep the copy marked "Enrollee" for your records.**

1. I understand that Basic Blue Rx (PDP) is a Prescription Drug Plan with a Medicare contract. MII Life Insurance, Inc. is the underwriter for Basic Blue Rx, a prescription drug plan with a Medicare contract. Enrollment in Basic Blue Rx depends on contract renewal. MII Life Insurance, Inc. and each Blue Cross® and/or Blue Shield® plan are independent licensees of the Blue Cross® and Blue Shield® Association.

2. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage.

3. I understand that if I am getting assistance from a sales agent, broker or other individual offering Basic Blue Rx, he/she may be paid based on my enrollment in Basic Blue Rx.

4. **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that Basic Blue Rx will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Basic Blue Rx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

5. I understand that beginning on the date Basic Blue Rx coverage begins, I must get all of my prescription drug services from Basic Blue Rx. Prescription drugs authorized by Basic Blue Rx and contained in my Basic Blue Rx Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Basic Blue Rx will pay for these services.**

Enrollee name: _____

## F. Signature

I want to transfer from my current plan option to the plan option I have selected here. I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this change form, including the information in Section E. 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 by Medicare. The information on this change 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.

**Your Signature:** _____ **Today's Date:** _____

☐ I give permission to the licensed agent identified below to enter my change form online through **BasicBlueRx.com.**

### For authorized representative use only

If you are the **authorized representative,** you **MUST** sign above and provide the following information:

Name (Print): _____ Phone number: _____

Address: _____ City: _____ State: ZIP Code: _____

Relationship to Enrollee: _____

☐ I want all mail for this member sent to me.

### For agent use only

☐ Check if you have received this **completed** enrollment form with the enrollee's signature from the enrollee. This paper form must be submitted using one of the methods below within **two (2) calendar days** of the date you receive it. Sign and date below when you receive the form from the beneficiary.

Check selected submission method and enter information as appropriate:

☐ Paper to online application. Enter online confirmation number:_____

☐ Application faxed. Enter date faxed (keep fax confirmation sheet):_____

☐ Application sent overnight. Be sure to keep the overnight receipt.

Agent Name (Print): _____

National Producer Number (NPN): _____

Agent signature: _____

Date form received: _____ Phone number: _____

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## Questions?

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-376-2185 (TTY: 711).

Chinese:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-376-2185 (TTY：711）。

Basic Blue Rx complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

MII0057 (09/18)