Basic Blue® Rx (PDP)

A Medicare Prescription Drug Plan

2019 Individual Enrollment Form

Easy ways to enroll

Enroll online at **BasicBlueRx.com**

Call **1-888-575-7519**, 8 a.m. to 8 p.m., daily, local time
(TTY hearing impaired users call **711**)

Contact your licensed sales representative

Fill out the enrollment form and place in mail

Basic Blue Rx
PO Box 3566
Scranton, PA 18505

Questions? Review the Summary of Benefits included in your 2019 Basic Blue Rx Enrollment Kit. Or call our Medicare Solutions specialists at the phone number above or your licensed sales representative.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-575-7519** (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 1-888-575-7519（TTY：711）。

ORIGINAL

2019 Basic Blue Rx prescription drug plan individual enrollment form

Instructions: Please complete all sections of this form. Please read each statement in Section H. Sign and date where indicated in Section I. For information call a Medicare Solutions specialist at the number on the front of this form.

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A. Personal information (please print clearly)

Last name: First name: Middle initial:

☐ Mr. ☐ Mrs. ☐ Ms. | ☐ Male ☐ Female | Birth date: (mm/dd/yyyy) _____

Home phone number: | Alternate phone number (optional): | Email address (optional):

Permanent residence street address **(P.O. Box is not allowed)**:

City: | State: | ZIP code:

Mailing address (only if different from your Permanent residence street address):

City: | State: | ZIP code:

B. Choose your plan option (for premium information, see your Summary of Benefits)

☐ Basic Blue Rx Value ☐ Basic Blue Rx Standard

C. 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 (mm/dd/yyyy):

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Enrollee name: _____

D. Paying your plan premium

Please select a 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:

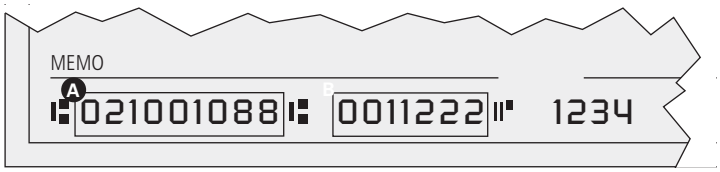
Account holder name: _____

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 you may owe) 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. 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 Social Security, RRB or EFT 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.

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

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/medicare/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.

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Enrollee name: _____

E. Enrollment period determination

Typically, you may enroll in a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll 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. **Note: A choice of effective dates is only allowed in the enrollment situations identified below.** In all other cases, or if you do not specify an effective date, your effective date will be the first of the month after your form is received by the plan.

☐ I am enrolling during the annual enrollment period, October 15 through 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 am new to Medicare. My Medicare Part A effective date is (mm/dd/yyyy): _____ and Part B is: _____.

☐ 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) _____. Requested effective date is (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 enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) of January 1 to March 31.

☐ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medcaid) on (mm/dd/yyyy) _____.

☐ I am leaving employer or union coverage on (mm/dd/yyyy) _____. Requested effective date is (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) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) or was notified of the loss (whichever is later). I lost my drug coverage on (mm/dd/yyyy) _____. Requested effective date is (mm/dd/yyyy) _____.

☐ I was recently 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 am leaving my Medicare Advantage plan within 12 months of my initial enrollment under a special enrollment period to go back to a Medigap (Medicare Supplement) plan as of (mm/dd/yyyy) _____.

☐ I am being disenrolled from a special needs plan because my condition does not qualify me for that plan as of (mm/dd/yyyy) _____.

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Enrollee name: _____

☐ I am being disenrolled from my existing plan due to its non-renewal as of (mm/dd/yyyy) _____. (Note: The enrollment period for this is December 8 – February 28. Enrollments received in December, January or February are effective the first of the next month.)

☐ I have been disenrolled from a Medicare Advantage prescription drug plan due to loss of Part B but continue to be entitled to Part A as of (mm/dd/yyyy) _____.

☐ I recently obtained lawful presence status in the U.S. I got this status on (mm/dd/yyyy) _____.

☐ 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 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 these statements apply to you, please contact our Medicare Solutions specialists (the phone numbers are on the front of this form) to see if you are eligible to enroll.

If you would prefer that we send you information in a language other than English or in an accessible format, please contact our Medicare Solutions specialists at the phone numbers listed on the front of this form.

F. Please answer the following questions to help Medicare coordinate your benefits

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Veteran Affairs benefits or State pharmaceutical assistance programs.

   Will you have other **prescription** drug coverage in addition to Basic Blue Rx? ☐ Yes ☐ No

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

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

   _____ _____ _____

2. 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 the institution: _____

   Address and phone number of institution (number and street):

   _____

   _____

G. Stop - please read this important information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Basic Blue Rx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

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If you currently have health coverage from an employer or union, joining Basic Blue Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Basic Blue Rx. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

After carefully reading all statements in this section, please sign Section I of this form.

1. 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. It is my responsibility to inform Basic Blue Rx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in Basic Blue Rx will end that enrollment.

3. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the annual enrollment period (October 15-December 7) unless I qualify for certain special circumstances.

4. Basic Blue Rx serves a specific service area. If I move out of the area that Basic Blue Rx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Basic Blue Rx network pharmacies. Once I am a member of Basic Blue Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Basic Blue Rx when I get it to know which rules I must follow to get coverage.

5. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

6. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and/or Blue Shield plans offering Basic Blue Rx, he/she may be paid based on my enrollment in Basic Blue Rx.

7. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.

8. **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.

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I. Please sign below

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 application, including the information in Sections G and H.

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 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.

Your signature: _____ **Today's date:** _____

☐ I give permission to the licensed agent identified below to enter my enrollment 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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If you need more information

Visit **BasicBlueRx.com**

Call **1-888-575-7519**, 8 a.m. to 8 p.m., daily, local time (TTY hearing impaired users call **711**)

Contact your licensed sales representative

Basic Blue Rx does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities.

Please contact Basic Blue Rx at the phone numbers above if you need information in another language or format (for example, Braille or large print).