MEDICARE ADVANTAGE 2022 GROUP ENROLLMENT APPLICATION



If you have any questions about our plans, need help filling out this application, or need information in another format (Braille), please call 1-855-215-9237 (TTY 711).

HIGHMARK. WESTERN NEW YORK

8 a.m. to 5 p.m., Monday - Friday

Mailing Address: P.O. Box 80 • Buffalo, NY 14240

Physical Address: 257 West Genesee St. • Buffalo, NY 14202

PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Mambar plan coloction.	nty Schools Retirees
	□ Forever Blue 799 (PPO) Plan O □ Freedom Nation (PPO) □ BlueSaver (HMO) □
Effective Date	Member bill level selection: Group bill Member bill
PART 2 PLEASE TELL US ABOUT YOURS	SELF
Last Name	First Name Middle Initial _
	Gender □ M □ F □ Mrs. □ Ms.
Email Address (optional)	
PERMANENT RESIDENCE ADDRESS (P.	O. BOX IS NOT ALLOWED):
Street/Apartment #	
City	State County Zip Code
	Alternative Phone Number () area code
MAILING ADDRESS (ONLY IF DIFFEREN	·
Street/Anartment #	
City	State County Zip Code
City Part 3 medical eligibility informa	State County Zip Code
CityPART 3 MEDICAL ELIGIBILITY INFORMA Please take out your red, white, and blue	State County Zip Code
PART 3 MEDICAL ELIGIBILITY INFORMA Please take out your red, white, and blue Medicare card to complete this section.	State County Zip Code ATION Name (as it appears on your Medicare card):
PART 3 MEDICAL ELIGIBILITY INFORMA Please take out your red, white, and blue Medicare card to complete this section. or Attach a copy of your Medicare Card or your etter from Social Security or the Railroad	State County Zip Code ATION Name (as it appears on your Medicare card): Medicare Number
PART 3 MEDICAL ELIGIBILITY INFORMA Please take out your red, white, and blue Medicare card to complete this section. or Attach a copy of your Medicare Card or your etter from Social Security or the Railroad	State County Zip Code ATION Name (as it appears on your Medicare card): Medicare Number
PART 3 MEDICAL ELIGIBILITY INFORMA Please take out your red, white, and blue Medicare card to complete this section. or Attach a copy of your Medicare Card or your etter from Social Security or the Railroad	State County Zip Code ATION Name (as it appears on your Medicare card): Medicare Number
	State County Zip Code Name (as it appears on your Medicare card): Medicare Number Entitled to: Hospital (Part A) Effective Date///
PART 3 MEDICAL ELIGIBILITY INFORMA Please take out your red, white, and blue Medicare card to complete this section. or Attach a copy of your Medicare Card or your etter from Social Security or the Railroad	State County Zip Code Name (as it appears on your Medicare card): Medicare Number Entitled to: Hospital (Part A) Effective Date//

PAR	T 4 PLEASE LIST A PRIMAI	RY CARE DOCTOR FROM THE F	PROVIDER DIRECTORY	
Curr	ent Patient? □ Yes □ No			
PAR	T 5 PLEASE READ AND AN	SWER THESE QUESTIONS		
1.	Are you the retiree?	Yes □No		
	If YES, retirement date (MM/I	DD/YYYY)		
	If NO, name of retiree			
2.	Are you the spouse of the			
3.	Are you covering a spouse	e or dependents under this em	ployer or union plan? ☐ Yes	□No
	If YES, name of spouse			
	Name of dependents			
4.	Employee Health Benefits in addition to the plan in v	coverage, VA benefits, or EPN vhich you are re-enrolling?	ng other private insurance, TRIC C. Will you have other <u>prescripti</u> ☐ Yes ☐ No	on drug coverage
		coverage and your identification (I		
	Name of other coverage			
	ID# for this coverage		Group# for this coverage	
5.	Are you a resident in a lo	ig-term care facility such as a	nursing home? ☐ Yes ☐ No)
	If YES, please list the institut	ion's name, address, phone numb	er, and date of admission.	uito#
	Name	Street	S	in Code
	City	State	Data of Admission	ip code
	Phone () area code	County	Date of Admission (MM/DD/YYYY)	
6.		state Medicaid program?	□Yes □No	
•		A - dia - id mumb or		
7.	Do you, on you own or the private insurance, worke	ough your spouse, have any h rs' compensation, or VA benet	ealth insurance other than wed its? □Yes □No	icare, sucii as
			<u>:</u>	
	What is the name of your in	surance?		
8.	Do you or does your spou	se work? □ Yes □ No		al al Frantis
9.	Please check one of the b	oxes below if you want us to s	end you information in a langua	je otner than Englis
	□ Spanish □ Chinese □	∃Russian □ Other		
10). Please check one of the l	oxes below if you would prefe	r we send you information in an	otner format.
	□ Large print □ Braille	Audio CD Other		

PART 6 PLEASE READ AND SIGN ON PAGE 4

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

Highmark Blue Cross Blue Shield of Western New York 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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 if an enrollment period is available (example: annual enrollment period from October 15 — December 7), or under certain special circumstances.

Senior Blue HMO and Forever Blue PPO serve a specific service area. If I move out of the area that Senior Blue HMO or Forever Blue PPO 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 Senior Blue HMO or Forever Blue PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Senior Blue HMO or Forever Blue PPO 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 Senior Blue HMO coverage begins, I must get all of my health care from Highmark Blue Cross Blue Shield of Western New York, except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date Forever Blue PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Forever Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Highmark Blue Cross Blue Shield of Western New York and other services contained in my Senior Blue HMO or Forever Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HIGHMARK BLUE CROSS BLUE SHIELD OF WESTERN NEW YORK WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Highmark Blue Cross Blue Shield of Western New York, he/she may be paid based on my enrollment in Senior Blue HMO or Forever Blue PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Cross Blue Shield of Western New York will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Cross Blue Shield of Western New York 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. 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.

PART 7 ENROLLEE AUTHORIZATION

Enrollee Authorization

gnature					Today's Date			
ou are an authorized represe	ntative, you	ı must sign above	and provide	e the follov	ving information:			
		First Name			Middle Initial			
reet/Apartment#								
		State County		Z	Zip Code			
ome Phone Number ()		Relationship to Enrollee						
ease include a copy of yo	ur Power (of Attorney pape	erwork.					
Forever Blue 799 - Plan 34 Group Number 00416368 Class ID 0180 Subgroup	Group Bill	Forever Blue 799 - P Group Number Class ID Subgroup		Member Bill	Forever Blue 799 - P Group Number Class ID Subgroup		Group Bill	
Forever Blue 799 - Plan O Group Number 00402550 Class ID S120 Subgroup	Member Bill	BlueSaver HMO Group Number Class ID Subgroup	11448443 0048	Group Bill	BlueSaver HMO Group Number Class ID Subgroup	11448446 0048	Member B	
Freedom Nation PPO Group Number 00416368 Class ID 0028 Subgroup	Group Bill	Freedom Nation PP Group Number Class ID Subgroup		Member Bill	Forever Blue PPO 7 Group Number Class ID Subgroup		Group Bil	
0					Group Number			
Forever Blue PPO 751 Group Number 00416369 Class ID 0002 Subgroup	Member Bill	Group Number Class ID Subgroup			Class ID Subgroup			

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Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

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