

Paying your plan premium

You can pay your monthly plan premium 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 benefit check each month.

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.

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.

Please select a premium payment option:

Get a bill monthly

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 Saving

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

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 BCN Advantage? Yes No

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

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

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: _____

Address & phone number of the institution (number and street): _____

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

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

- Language other than English (for example, Spanish)
 Alternate format (for example, Braille or large print)

Please contact BCN Advantage at **1-877-469-2583 (877-4My-BLUE)** if you need information in another format or language than what is listed above. Our office hours are **8 a.m. to 8 p.m., seven days a week**. TTY users should call **1-800-481-8704**.



Please read this important information

If you currently have health coverage from an employer or union, joining BCN Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCN Advantage. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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 on the next page

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

BCN Advantage HMO 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. 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 when an enrollment period is available (Example: November 15 – December 31 of every year), or under certain special circumstances.

BCN Advantage serves a specific service area. If I move out of the area that BCN Advantage 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 BCN Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from BCN Advantage when I get it to know which rules I must follow in order 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 BCN Advantage coverage begins, I must get all of my health care from BCN Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCN Advantage and other services contained in my BCN Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BCN Advantage WILL PAY FOR SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BCN Advantage, he/she may be paid based on my enrollment in BCN Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that BCN Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BCN Advantage 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.

Please read and sign below

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 by BCN Advantage or by Medicare.

Signature _____

Today's date _____

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

Name: _____

Address: _____

Phone number: () _____

Relationship to enrollee: _____

Office use only:

Name of staff member/agent/broker (if assisted in enrollment) _____

Plan ID # _____ Effective date of coverage _____

ICEP/IEP _____ OEP _____ AEP _____ SEP (type) _____ Not Eligible _____

Independent agent name (please print legibly) _____

2-digit MA/GA ID #: 5-digit agent ID #:

If you're completing this on behalf of an enrollee**, please sign: _____

**You may only complete this form on behalf of enrollees who are physically unable to complete the form.

Agent received date ___/___/___ MA/GA received date ___/___/___

Please note: Not all Blue Care Network providers are contracted with BCN Advantage. Please verify that the primary care physician listed in this form is contracted with BCN Advantage by calling 1-877-469-2583 (877-4My-BLUE). TTY users should call the 1-800-481-8704.

Return form to: BCN Advantage, Mail Code C411, P.O. Box 5184, Southfield, MI 48086-5184

Note: Be sure to have member complete the "Attestation of Eligibility" on next page.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage. (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 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 (insert date) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- I am moving into, live in, or recently moved out of a long term care facility (for example, a nursing home or other long term care facility). I moved/will move into/out of facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- None of these statements applies to me.*

* Please contact BCN Advantage at 1-877-469-2583 (877-4My-BLUE) (TTY users should call 1-800-481-8704) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week.