



Medicare and more

**Group Member Enrollment Request Form
for BCN Advantage**

FOR BCNA ONLY	
Agent Receipt Date	/ /
MA/GA Receipt Date	/ /

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. BCN Advantage HMO is a health plan with a Medicare contract.

Please contact BCN Advantage if you need information in another language or format (Braille)

To enroll in BCN Advantage, please provide the following information:

Name of group sponsoring this coverage URMBT- General Motors Population			
Group number (group sponsoring this coverage can provide this)			
Your last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (/ /) (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Home phone number ()	Alternate phone number ()
Permanent residence street address (P.O. Box is not allowed)		County	
City	State	Zip Code	
Mailing address (only if different than permanent residence address)			
E-mail address (optional)			

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
 - Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.
- You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE		HEALTH INSURANCE	
SAMPLE ONLY			
Name _____			
Medicare Claim Number _____ - _____ - _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Is Entitled To:		Effective Date	
HOSPITAL (Part A)		_____	
MEDICAL (Part B)		_____	

Your effective date will not begin any sooner than the first of the month after this application is received. Enrollment applications received more than 90 days prior to the start date won't be accepted.

Please read and answer these important questions:

1. Are you the retiree of the group sponsoring this coverage? Yes No

If yes, retirement date (month/date/year): _____

If no, name of retiree: _____

2. Will the retiree covered by this plan also be covering a Medicare-eligible spouse or Medicare-eligible dependents under this plan? Yes No

If yes, name of spouse: _____

Name of dependents: _____

Is there a **non**-Medicare-eligible spouse or dependent covered under this plan? Yes No

If the spouse or dependents are under age 65, are covered by the group and will receive Blue Care Network coverage, please complete the Enrollment Change of Status form.

3. Do you work? Yes No

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

If you answered "yes" to this question and you don't need regular dialysis anymore, or 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.

5. Some individuals may have other coverage, including other private insurance, Worker's Compensation, VA benefits, State pharmaceutical assistance programs or State Medicaid program.

Will you have other prescription drug coverage in addition to BCN Advantage? Yes No

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

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

6. 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 of Institution: _____

Phone number of Institution: () _____

7. Since you became eligible for Medicare, have you had any coverage or insurance that included prescription drugs? Yes No New to Medicare

If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of the proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit **www.medicare.gov** or call 1-800-MEDICARE.

If you prefer to receive CMS-required information in a language other than English or in another format, such as Braille or large print, please contact BCN Advantage at 1-866-966-BLUE (2583). TTY users should call 1-800-431-7944. Office hours are 8 a.m. to 5 p.m., Monday through Friday.

Please fill in the name of your BCN Advantage primary care physician (PCP):

Not all Blue Care Network providers are contracted with BCN Advantage. Please verify that your PCP is contracted with BCN Advantage.

Last Name

First Name

City

Please read and sign below:

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

BCN Advantage 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 only be in one Medicare Advantage plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. I understand that if enrollment forms are submitted for more than one plan with the same effective date, all attempted enrollments may be cancelled. It is my responsibility to inform BCN Advantage 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 November 15 - December 31), or under certain special circumstances, by sending a request to BCN Advantage or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048. Medicare is available 7 days a week, 24 hours a day.

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* document from BCN Advantage when I get it to know which rules I must follow in order to get coverage with this Medicare health 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 of 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 UNAUTHORIZED SERVICE.**

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.

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

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 could be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where I live) on this application means that I have read and understand the contents of this application.

Your signature*

Today's date

* Or the signature of the person authorized to act on my behalf under the laws of the state where I live. 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 and by Medicare.

If you are the authorized representative, you must sign on page 3 and provide the following information:

Name _____

Address _____

Phone number (_____) _____

Relationship to enrollee _____

Agent/Office Use	Name of BCNA staff member (if applicable): _____		
Plan ID# _____	Effective date of coverage _____		
ICEP/IEP: _____	OEP: _____	AEP: _____	EP (type): _____
Agent name (print legibly) _____	Agent ID #	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	A ID# <input type="text"/> <input type="text"/>