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1 (800) 382-1003 (TTY)

# MedAdvantage™ Enrollment Form

• PLEASE PRINT IN INK •

## Important information

Please check which plan you want to enroll in:

\_\_\_\_\_ MedAdvantage + Rx  
with prescription drug coverage

\_\_\_\_\_ MedAdvantage without  
prescription drug coverage

|  |  |
|--|--|
|  |  |
|  |  |

|  |        |   |             |                 |
|--|--------|---|-------------|-----------------|
| Last Name  |        | First Name  |             | Middle Initial  |
| Birthdate (mm/dd/yyyy)   | Sex    | Social Security Number<br><i>(providing this information is optional)</i> |             | Medicare Number |
| Telephone Number Including Area Code<br>(     )                    |        | E-mail address:   |             |                 |
| <b>Your Permanent Residence Address:</b>                           |        |   |             |                 |
| Number   | Street |   | Apartment # |                 |
| City   | County | State   | Zip Code    |                 |
| <b>Your Mailing Address (if different from Permanent Address):</b> |        |   |             |                 |
| Number   | Street |   | Apartment # |                 |
| City   | County | State   | Zip Code    |                 |

**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 Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

|                            |   |
|----------------------------|---|
| Medicare Health Insurance  |   |
| Name of Beneficiary: _____ |   |
| Medicare Claim Number      | Sex   |
| ___ - ___ - _____          | <input type="checkbox"/> M <input type="checkbox"/> F |
| Is Entitled to             | Effective Date  |
| ___ Hospital (Part A)      | _____   |
| ___ Medical (Part B)       | _____   |

## Office use only

|                |      |         |       |           |         |
|----------------|------|---------|-------|-----------|---------|
| Effective Date | Rule | Group # | Pkg # | Alt. ID # | Agent # |
|----------------|------|---------|-------|-----------|---------|

**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 do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not 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 MedAdvantage?**

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 \_\_\_\_\_

\_\_\_\_\_

RX Bin# \_\_\_\_\_ RX PCN# \_\_\_\_\_

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 and Phone Number of Institution (number and street) \_\_\_\_\_

4. Are you enrolled in your State Medicaid program?

Yes  No

If "yes," please provide your Medicaid Number \_\_\_\_\_

5. Did you move into this plan's service area within the past six months?

Yes  No

If "yes," what date? \_\_\_\_\_

*Date*

6. Do you or your spouse work?

Yes  No

7. Are you currently enrolled in a Regence BlueCross BlueShield of Utah individual medical plan or Medicare supplement plan?

Yes  No

If yes, do you wish to terminate that coverage?

Yes  No

**If you answered "yes" to both of the above questions, please sign the statement below:**

I, \_\_\_\_\_ wish to terminate my coverage from \_\_\_\_\_ effective on the date of this MedAdvantage policy.

Signature ➤ \_\_\_\_\_ Date \_\_\_\_\_

# STOP

## Please read this important information

**If you currently have health coverage from an employer or union, joining MedAdvantage + Rx could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining MedAdvantage + Rx may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

### Your Plan Premium Options

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we can automatically deduct your premium from your bank account or we can send you a monthly or quarterly bill. Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check?**  Yes  No

OR

**Would you like us to automatically deduct your premium from your bank account? (A completed SurePay form is required)**  Yes  No

OR

**Would you like us to bill you monthly or quarterly?**  Monthly  Quarterly

***IMPORTANT – Only choose one of the above options.***

### Emergency Information

|  |                              |                     |          |
|--|------------------------------|---------------------|----------|
| Name of relative or friend other than spouse | Telephone Number<br>(      ) | Relationship to you |          |
| Number                                       | Street                       | Apartment #         |          |
| City   | County                       | State               | Zip Code |

**(Important: Signature Required on page 4)  
Please continue on next page**

## Please Read and Sign Below

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

Regence BlueCross BlueShield of Utah MedAdvantage is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to MedAdvantage or by calling 1 (800) Medicare. TTY users should call 1 (877) 486-2048.

MedAdvantage serves a specific service area. If I move out of the area that MedAdvantage 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 MedAdvantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the MedAdvantage Evidence of Coverage document from MedAdvantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

**I understand that, beginning on the date my MedAdvantage coverage begins, I can go to doctors, specialists or hospitals in or out of-the-network. I also understand that I may have to pay more for out-of-network services. I understand that services authorized by MedAdvantage and other services contained in my MedAdvantage plan Evidence of Coverage document will be covered. I also understand that without authorization, NEITHER MEDICARE NOR MEDADVANTAGE WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give Medicare or their agents the information needed to run the Medicare program. 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 behalf of the individual under the laws of the State where the individual resides) 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 this person is authorized under State law to complete this enrollment.

**Your Signature \*** ➤ \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year

\*If you are the authorized representative, you must provide the following information and attach a copy of proof of Legal Guardianship or proof of authorization by state law.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to enrollee

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone number