

ENROLLMENT APPLICATION



INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

Please contact FreedomBlue PPO at 1-866-682-7969 (TTY users should call 711) to inquire about materials on audio CD or for telephone translation services. Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

WAYS TO ENROLL



Mail: Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Highmark FreedomBlue PPO
P.O. Box 535042
Pittsburgh, PA 15253-9923



Phone: Complete your application over the phone toll-free at **1-866-682-7969** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.



Online: Complete your application online at **www.highmarkbcbs.com/medicare**



In person: Bring your application to a Medicare Solutions Seminar or other Highmark authorized locations. Call the toll-free number to find a meeting in your area.

West Central

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

I understand that FreedomBlue PPO will notify me in writing of my confirmed effective date of enrollment in FreedomBlue PPO. I understand that, typically, my effective date will be the first of the month following the month in which FreedomBlue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in FreedomBlue PPO.

FreedomBlue PPO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and Part 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. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need know how you would prefer to pay it. You can pay 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. 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 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. 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: October 15 – December 7 of every year), or under special circumstances.

FreedomBlue PPO serves a specific service area. If I move out of the area that FreedomBlue 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 FreedomBlue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from FreedomBlue 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 the FreedomBlue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

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STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

I understand that beginning on the date FreedomBlue 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, FreedomBlue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by FreedomBlue PPO and other services contained in my FreedomBlue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOMBLUE PPO 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 FreedomBlue PPO, he/she may be paid based on my enrollment in FreedomBlue PPO.

RELEASE OF INFORMATION:

By joining this Medicare health plan, I acknowledge that FreedomBlue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that FreedomBlue PPO 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.

PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment

and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Department.

PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 Railroad Retirement Board benefit check or be billed directly by Medicare. **DO NOT** pay FreedomBlue PPO the Part D-IRMAA.

AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Number:		Agency Number:

Please press hard. You are making two copies. Do not separate form until after completing and signing.

TO ENROLL IN FREEDOMBLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (No P.O. Boxes)	Apt#	City	State	Zip
				County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip
				Date of Birth / /
Home Phone (with area code) ()	Email Address (if applicable)			

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 Social Security or the Railroad Retirement Board.

Medicare Health Insurance

SAMPLE ONLY

Name _____

Medicare Claim Number _____ Sex _____

Is Entitled To _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A & Part B to join a Medicare Advantage Plan.

PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:

- HD – \$0 per month
- Classic – \$166 per month
- Select – \$73 per month

PAYING YOUR PLAN PREMIUM:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) or on the web with eBill 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 you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill. Information about EFT and eBill will be included with your first bill.

- Monthly Quarterly Semi-Annually Annually
- Automatic deduction from your monthly Social Security or RRB benefit check. (The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.)

OTHER INSURANCE

- Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield health plan other than KeystoneBlue? Yes No
If YES, name of plan: _____
- Will either you or your spouse be employed once enrolled in FreedomBlue PPO? Self: Yes No
Spouse: Yes No
Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____
- Will you have any Health Insurance and/or Prescription Drug Coverage other than FreedomBlue PPO or Medicare that will continue after your enrollment? Yes No

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

READ AND ANSWER THESE IMPORTANT QUESTIONS

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

Name of Provider (recommended)	PCP/NPI # (from the enclosed Provider Directory)
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The FreedomBlue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in FreedomBlue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)*Yes No

Do you have End-Stage Renal Disease?Yes No
If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Are you enrolled in your State Medicaid program?Yes No
If "YES," please provide your Medicaid Number: _____

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): _____

STOP! Please read this important information. If you currently have health care coverage from an employer or union, joining FreedomBlue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join FreedomBlue PPO. 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 benefit administrator or the office that answers questions about your coverage can help.

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 FreedomBlue PPO or by Medicare.

Signature	Today's Date
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If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

PLEASE RETURN THE TOP COPY OF THIS FORM AND KEEP THE BOTTOM COPY FOR YOUR RECORDS.

HIGHMARK  | FreedomBlue PPO

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association



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WEST CENTRAL