Enrollment request for Hope College 51623-601

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Hope HR Admn: 1) Write effective date on top of form 2) email completed form to mwilson3@bcbsm and vschmidt@bcbsm.com to process

Please provide the following information. Please print.			
☐ Mr. ☐ Ms. ☐ Mrs.	First name Middle initial Last name		
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number (Optional)
Permanent residence street address			City / State
ZIP code	County (Optional)	Email address (Optional)	
Mailing address (*if different from your permanent residence address*)			
Street address	City	State	ZIP code
Optional information			
Emergency contact name			
Relationship to you	Telephone number		

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A or Part B, or both to join a Medicare Advantage plan.	

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): _____ If no, name of retiree: _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependents under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Some individuals have other drug coverage, including other private insurance, workers compensation, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to <plan name>? If yes, please list your other coverage and identification number(s) for this coverage: Name of other coverage: _____ ID # for coverage: _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: _____	☐ **Yes** ☐ **No**
6. Please enter the name of your primary doctor (Optional): _____	**Primary doctor's telephone:**

This enrollment application is part of your <Medicare Plus Blue Group PPO> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

All fields in this section are optional
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese

☐ Chinese	☐ Native Hawaiian	☐ White
☐ Filipino	☐ Other Asian	☐ **I choose not to answer**

Please contact <Medicare Plus Blue Group PPO> Customer Service at <**1-866-684-8216**> (TTY users call **711**) if you need information in an accessible format or language other than what is listed below.

Customer Service hours are 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). You can also visit us at **www.bcbsm.com/medicare**.

Select one if you want us to send you information in a language other than English.

☐ English (default) ☐ Spanish ☐ Other (language other than English)

Select one if you want us to send you information in an accessible format.

☐ Large print ☐ Audio CD

Important: Please read and sign below.

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

<Medicare Plus Blue Group PPO> 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 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 do not 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, or under certain special circumstances. As a Medicare Advantage PPO member, <Medicare Plus Blue Group PPO> works differently than a Medicare supplemental plan. <Medicare Plus Blue Group PPO> pays instead of Medicare, and I will be responsible for the amounts that <Medicare Plus Blue Group PPO> does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in <Medicare Plus Blue Group PPO>.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will or my out-of-pocket costs may be greater. Out-of-Network/non-contracted providers are under no obligation to treat <Medicare Plus Blue Group PPO> members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

<Medicare Plus Blue Group PPO> serves a specific service area. If I move out of the area that <Medicare Plus Blue Group 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 <Medicare Plus Blue Group 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 <Medicare Plus Blue Group PPO> when I receive it to know which rules I must follow in order to receive 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 <Medicare Plus Blue Group PPO> coverage begins, I must get all of my health care from <Medicare Plus Blue Group PPO>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <Medicare Plus Blue Group PPO> and other services contained in my <Medicare Plus Blue Group PPO> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR <Medicare Plus Blue Group PPO> WILL PAY FOR THE SERVICES.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with <Medicare Plus Blue Group PPO>, he/she may be paid based on my enrollment in <Medicare Plus Blue Group PPO>.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the <Medicare Plus Blue Group PPO> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <Medicare Plus Blue Group PPO> who 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 by <Medicare Plus Blue Group PPO> or by Medicare.

Please sign below.
By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flyer.

Signature:	Today's date:

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

Name		
Address		
City	State	ZIP code
Phone number	Relationship to enrollee	

Please send your completed enrollment application to:

Hope College HR Benefits Office
100 E. 8th Street Suite 210
Holland, MI 49423
benefits@hope.edu