blue california

2022 Enrollment Request Form Blue Shield 65 Plus (HMO) Employer Group/Union Health Plan

Please contact Blue Shield 65 Plus if you need information in another language or format (Braille).

To enroll in Blue Shield 65 Plus, please provide the following Information:

Employer Group or Union Name

SAUSD

Group or Union No. (leave blank if not provided by your employer group or union)

W05153 2

Last Name

☐ Mr. ☐ Mrs. ☐ Ms.

First Name

(optional): Middle initial

Birth Date: (MM/DD/YYYY)

Phone Number

(optional): ☐ Landline ☐ Cell

Sex ☐ M ☐ F

Alternate Phone Number **(optional):**

(optional): ☐ Landline ☐ Cell

Permanent residence street address (P.O. Box is not allowed):

Street Address

City State ZIP Code

Mailing address, if different from your permanent address (P.O. Box allowed):

Street Address

City State ZIP Code

Email Address (Optional, but required for electronic communications)

Go paperless! Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

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 and Part B to join a Medicare Advantage plan.

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

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

   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

3. Do you or your spouse work? ☐ Yes ☐ No

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

   Will you have other prescription drug coverage in addition to Blue Shield 65 Plus (HMO)? ☐ Yes ☐ No

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

   Name of other coverage: _____

   ID # for Coverage: _____

5. 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 Institution (number and street):

   _____

Optional field: **Please choose a Primary Care Physician (PCP), or affiliated medical group:**

Physician Name or affiliated Medical Group:

Physician ID #:

Physician Group Name:

Current patient? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish

☐ Large print

Please contact Blue Shield 65 Plus at **(800) 776-4466** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8.pm., seven days a week. TTY users should call **711**.

Please read and sign below

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

Blue Shield 65 Plus 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 get 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 October 15 – December 7), or under certain special circumstances.

Blue Shield 65 Plus serves a specific service area. If I move out of the area that Blue Shield 65 Plus 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 Blue Shield 65 Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Shield 65 Plus 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 beginning on the date Blue Shield 65 Plus coverage begins, I must get all of my health care from Blue Shield 65 Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus and other services contained in my Blue Shield 65 Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS 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 Blue Shield 65 Plus, he/she may be paid based on my enrollment in Blue Shield 65 Plus.

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 acknowledge that Blue Shield 65 Plus 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.

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 from Medicare.

Signature	**Today's Date**
	☐☐/☐☐/☐☐☐☐

If you're the authorized representative, sign above, and fill out these fields:

Name:

Street Address:

City | State | ZIP code

Phone Number:

Relationship to Enrollee:

Please return your completed enrollment form to your Benefits Administrator or send to:

Email: benefits@sausd.us

Mail: Benefits Office
1601 E Chestnut Ave
Santa Ana, CA 92701-6322

Fax: (714) 558-5682

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Meeting #: _____

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas, benefits and provider networks.