2022 Individual Enrollment Request Form
Blue Shield Inspire (PPO)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Email, Mail, or Fax your completed and signed form to:

Email: WHMembership@blueshieldca.com

Mail: Blue Shield of California
PO Box 948
Woodland Hills, CA 91365-9856

Fax: (877) 251-3660

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call your Authorized Agent or your Blue Shield Representative at **(888) 534-4263**. TTY users can call **711**. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048

En español: Llame a su Agente Autorizado o a su Representante de Blue Shield al **(888) 534-4263**. Los usuarios del sistema TTY pueden llamar al 711 o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

☐ Blue Shield Inspire (PPO) in Alameda County ($99 per month)

Please indicate if you would like to enroll in the Optional Supplemental Dental PPO plan

☐ Optional Supplemental Dental PPO plan ($41.90 per month)

First Name

(optional): Middle Initial

Last Name

Sex ☐ M ☐ F

Birth Date: (MM/DD/YYYY)

Phone Number

(optional): ☐ Landline ☐ Cell

Alternate Phone Number **(optional):**

(optional): ☐ Landline ☐ Cell

Optional: I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply. ☐ Yes ☐ No

Participation is voluntary and you can opt-out at any time, for more information visit **blueshieldca.com/terms**.

Email address (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.

Permanent Residence street address (Don't enter a P.O. Box):

Street Address

City

State

ZIP code

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

Street Address

City

State

ZIP code

Your Medicare information:

Medicare Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Shield Inspire (PPO)?

☐ Yes ☐ No

Prescription drug coverage

Name of other coverage:

ID # for this coverage:

Group #:

Medical coverage

Name of other coverage:

ID # for this coverage:

Group #:

Are you enrolled in your State Medicaid (Medi-Cal) Program? ☐ Yes ☐ No
If yes, provide your Medicaid (Medi-Cal) number

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Shield Inspire (PPO).
- By joining this Medicare Advantage Plan, I acknowledge that Blue Shield Inspire (PPO) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Blue Shield Inspire (PPO) coverage begins, I must get all of my medical and prescription drug benefits from Blue Shield Inspire (PPO). Benefits and services provided by Blue Shield Inspire (PPO) and contained in my Blue Shield Inspire (PPO) *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my Blue Shield Inspire (PPO) will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

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:

Section 2 – 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.

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

☐ Spanish ☐ Chinese

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

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Customer Care at **(800) 776-4466** [TTY users should call **711**] 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 p.m., seven days a week, year-round.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more.

☐ I am willing to receive required plan materials via email (i.e., enrollment notifications and Annual Notice of Changes) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations, and plan newsletter) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Customer Care at the number on your plan ID card.

Paying your plan premiums:

You can pay your monthly plan premium (including any late enrollment penalty you currently have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or you may choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

To learn more about your payment options, visit us at **blueshieldca.com/medicarewaystopay** or call Customer Care at **(800) 776-4466 TTY: 711.**

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Shield of California the Part D-IRMAA.

Producer information: Producer name and ID or NPN **is required**.

Agency name: ______________________________

(please print appointed agency name)

Agency ID #: ______________________________

(please print agency tax ID)

Producer (writing agent) name (required): ______________________________

(please print writing agent name)

Producer ID #: ______________________________

(please print agent tax ID number)

Producer (writing agent) NPN or TIN (one required): ______________________________

(please print NPN or TIN number)

Producer phone number: ______________________________

Producer email address: ______________________________

Date application received by producer: ______________________________

Producer signature: ______________________________

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date).

☐ I recently was released from incarceration. I was released on (insert date).

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date).

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date).

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date).

- [ ] I recently left a PACE program on (insert date).

- [ ] I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).

- [ ] I am leaving employer or union coverage on (insert date).

- [ ] I belong to a pharmacy assistance program provided by my state.
- [ ] My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- [ ] I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date).

- [ ] I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan. I was disenrolled from the SNP on (insert date).

- [ ] I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- [ ] I'm in a plan that was recently taken over by the state or territorial regulatory authority because of financial issues. I want to Switch to another plan.
- [ ] I'm in a plan that had a star-rating less than 3 stars for the last 3 years. I want to join a plan with a star rating 3 stars or higher.
- [ ] I am new to Medicare AND Medicare entitlement was made retroactively so I was notified about getting Medicare after my Part A and/or B effective date.

If none of these statements applies to you or you're not sure, please contact Blue Shield of California at **(888) 534-4263 (TTY: 711)** or Authorized Agent, to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.