Individual Enrollment Request Form

Instructions for Medicare Advantage Plan (Part C)

CareFirst Medicare Advantage

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?

Send your completed and signed form to:

CareFirst BlueCross BlueShield Medicare Advantage Enrollment
P.O. Box 3236, Scranton PA 18505

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

How do I get help with this form?

Call CareFirst BlueCross BlueShield Medicare Advantage at 833-536-2001. 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 CareFirst BlueCross BlueShield Medicare Advantage al 833-536-2001/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

SECTION 1—ALL FIELDS IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

Service Area *Based on the county in which you reside.*	**Plan and Premium**
MARYLAND: Allegany, Anne Arundel, Caroline, Carroll, Cecil, Charles, Dorchester, Garrett, Howard, Harford, Kent, Montgomery, Prince Georges, Queen Anne's, Talbot, Calvert, Frederick. St. Mary's, Somerset, Washington, Wicomico, and Worcester. **Not available in Baltimore City and Baltimore County.**	CareFirst BlueCross Blue Shield Advantage Essential (PPO) ○ Premium: $0 per month
MARYLAND: Allegany, Anne Arundel, Baltimore, Baltimore City, Caroline, Carroll, Cecil, Charles, Dorchester, Garrett, Howard, Harford, Kent, Montgomery, Prince Georges, Queen Anne's, Talbot, Calvert, Frederick. St. Mary's, Somerset, Washington, Wicomico, and Worcester.	CareFirst BlueCross Blue Shield Advantage Complete (PPO) ○ Premium: $42 per month
DISTRICT OF COLUMBIA	CareFirst BlueCross Blue Shield Advantage Complete (PPO) ○ Premium: $42 per month

CONTACT INFORMATION

FIRST Name:	LAST Name:	Middle Initial (optional):

Birth Date:	Sex: ○ Male ○ Female	Phone Number:	Mobile Phone (optional):

Permanent Residence Street Address (Note: For individuals experiencing homelessness, a PO Box may be considered your permanent address.):		County (optional):
City:	State:	ZIP Code:

Mailing Address, if different from your Permanent Address (PO Box allowed):

City:	State:	ZIP Code:

Email Address: (optional)

YOUR MEDICARE INFORMATION

Medicare Number:	Part A Effective Date:	Part B Effective Date:

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareFirst BlueCross BlueShield Medicare Advantage? ○ Yes ○ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD	
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 this information is incorrect, you may be disenrolled.	
	I am new to Medicare.
	I am making a change during the Annual Enrollment Period (AEP) from October 15 to December 7.
	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 to March 31.
	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 qualification required to be in that 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 am enrolled in a plan that has been identified with the low performing icon (LPI).
	I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1–March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.
	I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).

INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD (CONTINUED)

If none of these statements applies to you or you're not sure, please contact CareFirst BlueCross BlueShield Medicare Advantage at **833-536-2001 (TTY: 711)** to see if you are eligible to enroll. We are open October 1 through March 31, seven days a week from 8 a.m. – 8 p.m., and April 1 through September 30, Monday through Friday from 8 a.m. – 8 p.m.

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.

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

- ○ No, not of Hispanic, Lantino/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
- ○ Chinese ○ Filipino ○ Guamanian or Chamorro ○ Japanese ○ Korean
- ○ Native Hawaiian ○ Other Asian ○ Other Pacific Islander ○ Samoan
- ○ Vietnamese ○ White ○ Other ○ **I choose not to answer**

What is your gender? Select one.

- ○ Woman ○ I use a different term: _____
- ○ Man ○ **I choose not to answer**
- ○ Non-binary

Which of the following best represents how you think of yourself? Select one.

- ○ Lesbian or gay ○ I use a different term: _____
- ○ Straight, that is, not gay or lesbian ○ I don't know.
- ○ Bisexual ○ **I choose not to answer**

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

- ○ Spanish

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

- ○ Braille ○ Large print ○ Audio CD ○ Data CD

Please contact CareFirst BlueCross BlueShield Medicare Advantage at 833-536-2001 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m.– 8 p.m. ET, 7 days a week from October 1 through March 31. From April 1 through September 30, our hours are 8 a.m.–8 p.m. ET, Monday through Friday. TTY users should call 711.

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

SECTION 3—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) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month**.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. 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. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. Don't pay CareFirst BlueCross BlueShield Medicare Advantage the Part D-IRMAA.

People with limited incomes may qualify for ***Extra Help*** to pay for their prescription drug costs. If eligible, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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.ssa.gov/medicare/part-d-extra-help**.

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.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- ○ Get a bill by mail
- ○ Electronic funds transfer (EFT) from your bank account each month. I authorize CareFirst BlueCross BlueShield Medicare Advantage to deduct my monthly plan premium from my bank account. I understand my account will be deducted on the 5th of the month or the next banking day. Please enclose a VOIDED check or provide the following:

Account holder name:	Bank routing number:
Bank account number:	Account type: ○ Checking ○ Saving

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

I hereby authorize CareFirst BlueCross BlueShield Medicare Advantage to deduct from my account listed above my monthly plan premium and any late enrollment penalty, as applicable.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CareFirst BlueCross BlueShield Medicare Advantage has received written notification from me of its termination in such time and such manner as to afford CareFirst BlueCross BlueShield Medicare Advantage and the Financial Institution a reasonable opportunity to act on it. If my Financial Institution information changes, I agree to submit to CareFirst BlueCross BlueShield Medicare Advantage an updated EFT Authorization Agreement. EFT transactions will occur on the 5th of the month in the amount of the balance due in monthly plan premiums and late enrollment penalties, if applicable, for the current month.

How to cancel automatic withdrawal:

Termination requests must be received prior to the end of the month before the termination date (ex: Termination is October 1 so the request must be received by September 30). Your automatic withdrawal will not stop unless the termination request is received by the end of month prior to the next withdrawal. Termination requests can be faxed to 855-215-6947, or they can be mailed to CareFirst BlueCross BlueShield Medicare Advantage, Attention: Premium Billing, P.O. Box 3236, Scranton, PA 18505. Termination requests will be processed in the order received. You will be responsible for any fees incurred by their bank, such as non-sufficient funds (NSF).

SECTION 4—IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareFirst BlueCross BlueShield Medicare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that CareFirst BlueCross BlueShield Medicare Advantage 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.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 CareFirst BlueCross BlueShield Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareFirst BlueCross BlueShield Medicare Advantage. Benefits and services provided by CareFirst BlueCross BlueShield Medicare Advantage and contained in my CareFirst BlueCross BlueShield Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareFirst BlueCross BlueShield Medicare Advantage 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:	Address:
Phone Number:	Relationship to Enrollee:

SECTION 5—FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY	
Complete this section if you're an indivdual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.	
Name:	Relationship to enrollee:
Signature	National Producer Number (Agents/Brokers only):

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.

Office/Agent Use Only	
Initial Receipt Date	
Name of Field Marketing Organization (FMO):	
Plan ID #:	Effective Date of Coverage:
Election Period Choice: ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____	
Plan Code / Plan Option	

Send the completed application to:

CareFirst Advantage Inc.
P.O. Box 3236
Scranton, PA 18505

Or FAX to: 1-855-215-6948