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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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

Select the plan you want to join:

CareFirst BlueCross BlueShield Advantage Salute (PPO)

Maryland	○ Premium: $0 per month
Washington, D.C.	○ Premium: $0 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 (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:

Are you a Military Retiree or Veteran of the U.S. Uniformed Services? (optional)

○ Yes, Military Retiree ○ Yes, Veteran ○ No

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

What branch of the Military did you serve with? (optional)

○ Air Force ○ Army ○ Coast Guard ○ Marine Corps ○ Navy ○ Space Force

○ NOAA Commissioned Corps ○ PHS Commissioned Corps

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 ○ Data CD ○ Audio 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

INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD (CONTINUED)

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.

INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD	
	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).
If none of these statements applies to you or you're not sure, please contact CareFirst BlueCross BlueShield Medicare Advantage at **833-536-2001** 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 3—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 plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or 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 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 4—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	

CareFirst BlueCross BlueShield Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Medicare Advantage depends upon contract renewal.

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.