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 833-473-0394. TTY users can call 771.

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 833-473-0394/771 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 ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

◯ **CareFirst BlueCross BlueShield Advantage Core (HMO)** • $35.00 per month

◯ **CareFirst BlueCross BlueShield Advantage Enhanced (HMO)** • $95.00 per month

◯ **Dental and Vision Add-On** • $17.00 per month (Available for purchase with CareFirst BlueCross BlueShield Advantage Enhanced (HMO) only.)

FIRST Name:	LAST Name:	Middle Initial

Birth Date: (M M / D D / Y Y Y Y)	Sex: ◯ Male ◯ Female	Home Phone Number: ( )
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Permanent Residence Street Address (Don't enter a PO Box):		County:
City:	**State:**	**ZIP Code:**
Mailing Address, if different from your Permanent Address (PO Box allowed):		
City:	**State:**	**ZIP Code:**

YOUR MEDICARE INFORMATION

Medicare Number:

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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:

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.
- 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.

IMPORTANT: READ AND SIGN BELOW (CONTINUED)

- 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 2—ALL FIELDS BELOW 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

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

◯ Braille ◯ Large print ◯ Audio CD

Please contact CareFirst BlueCross BlueShield Medicare Advantage at 855-290-5744 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

List your Primary Care Physician (PCP), clinic, or health center:

Provider ID Number (NPI):

E-mail address:

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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying 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. DO NOT 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 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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.socialsecurity.gov/prescriptionhelp**.

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
- ◯ Electronic funds transfer (EFT) from your bank account each month. 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.)

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	
Name of Agent and Agent NPN:	
Name of Field Marketing Organization (FMO) and FMO NPN:	
Plan ID #:	Effective Date of Coverage:
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____	

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