Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 12625
Salem, OR 97309-0625
1-888-REGENCE
(1-888-734-3623)
1 (800) 382-1003 (TTY)

Regence MedAdvantage Enrollment Request Form

● **PLEASE PRINT IN INK** ●

Important Information
Please check which plan you want to enroll in:
☐ **Regence MedAdvantage + Rx Enhanced (medical and Rx plan) $121.00**
☐ **Regence MedAdvantage + Rx Classic (medical and Rx plan) $106.00**
☐ **Regence MedAdvantage + Rx Core (medical and Rx plan) $49.00**
☐ **Regence MedAdvantage (medical only plan) $75.00**

Name (Last)	(First)	(M.I.)

Birthdate (mm/dd/yyyy)	Sex	Social Security Number (providing this information is optional)	Medicare Number

Telephone Number (including area code)	**E-mail address**

Your Permanent Residence Address

Number	Street	Apartment

City	County	State	ZIP Code (+4)

Your Mailing Address (if different from Permanent Address)

Number	Street	Apartment

City	County	State	ZIP Code (+4)

Emergency Information

Name of relative or friend other than spouse	Telephone Number	Relationship to you

Office Use Only

Effective Date	Election Type	Group #	Pkg #	Alt. ID #	Agent #

Please continue on next page

Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other **prescription** drug coverage in addition to Regence MedAdvantage? ☐ Yes ☐ No

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

   Name of other coverage ______________________________

   ID Number for this coverage ______________________________

   Group Number for this coverage ______________________________

   Rx BIN Number ______________ Rx PCN Number ______________

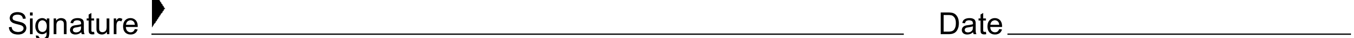
3. Do you or your spouse work? ☐ Yes ☐ No

4. Are you currently enrolled in a Regence BlueCross BlueShield of Oregon individual medical plan or Medicare supplement plan? ☐ Yes ☐ No

   If yes, do you wish to terminate that coverage? ☐ Yes ☐ No

   If you answered "yes" to both of the above questions, please sign the statement below:

   I, ______________________________ wish to terminate my coverage from ______________________________ effective on the date of this Regence MedAdvantage policy.



   Signature ______________________________ Date ______________

Please check the box below, if you would prefer us to send your information in another format:

☐ Large print, audio tape or CD

Please contact Regence MedAdvantage at 1-800-541-8981 (TTY users should call 1-800-382-1003) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m. seven days a week.

Please continue on next page

STOP
Please read this important information

If you currently have health coverage from an employer or union, joining Regence MedAdvantage + Rx Core, Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced could affect your employer or union health benefits.

If you have health coverage from an employer or union, joining Regence MedAdvantage + Rx Core, Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Paying Your Plan Premium:

You can pay your plan premium by mail each month or quarterly or by having it deducted from your bank account. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 does not cover.

Please select one plan premium payment option below. If you don't select a payment option, you will receive a bill each month.

Would you like us to automatically deduct your premium from your bank account? (A completed SurePay form is required.) ☐ Yes ☐ No

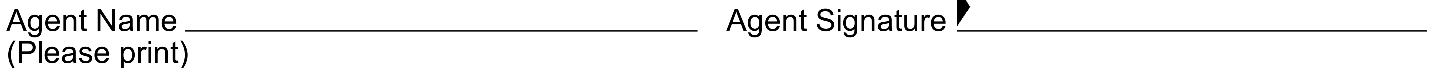
OR

Would you like us to bill you monthly or quarterly? ☐ Monthly ☐ Quarterly

OR

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction will begin approximately two months after your enrollment date. We will bill you for your premium until the Social Security deduction begins.) ☐ Yes ☐ No

Agent Use Only



Agent Name ______________________ (Please print)

Agent Signature ______________________

Agent Number ______________________

Agent Phone Number (   ) ______________________ (including area code)

Please continue on next page

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 recently moved outside of the service area for my current plan.
- ☐ I recently moved and this plan is a new option for me.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I receive extra help paying for Medicare prescription drug coverage.
- ☐ I am no longer eligible for extra help paying for Medicare prescription drugs.
- ☐ I live in or recently moved out of a long term care facility (for example, a nursing home or long term care facility). **Please provide the following information:**

Name of Institution ______________________________

Address and Phone Number of Institution (number and street) ______________________________

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- ☐ I recently left a PACE program.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- ☐ I am leaving employer or union coverage.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S.
- ☐ None of these statements applies to me.*

* Please contact Regence MedAdvantage at 1-800-541-8981 (TTY users should call 1 -800-382-1003) to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., seven days a week.

Please read and sign on page 5

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

Regence BlueCross BlueShield of Oregon MedAdvantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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 when an enrollment period is available (Example: November 15 - December 31 of every year), or under certain special circumstances.

(Important: Signature required on page 5)

Please read and sign below

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

Regence MedAdvantage serves a specific service area. If I move out of the area that Regence MedAdvantage 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 Regence MedAdvantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Regence MedAdvantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

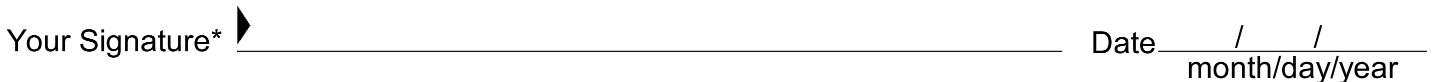
I understand that beginning on the date Regence MedAdvantage coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Regence MedAdvantage provides reimbursement for all covered benefits, even if received out-of-network. Services authorized by Regence MedAdvantage and other services contained in my Regence MedAdvantage Evidence of Coverage document will be covered. Without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE WILL PAY FOR THE SERVICES.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Regence MedAdvantage, he/she may be compensated based on my enrollment in Regence MedAdvantage. This compensation does not affect my premium in any way.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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 Regence MedAdvantage 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. I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give Medicare or their agents the information needed to run the Medicare program. 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 behalf of the individual under the laws of the State where the individual resides) 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 by Regence MedAdvantage or by Medicare.



Your Signature* ______________________________ Date ___/___/___
month/day/year

* If you are the authorized representative, you must sign above and provide the following information:

Name ______________________________ Relationship to enrollee ______________

Address ______________________________ Phone Number (   ) ______________

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