BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Advantage®

SHORT ENROLLMENT FORM

If you are changing plans within ***Blue Advantage,*** you should use this form. This form may not be used to enroll in Blue Advantage for the first time.

Name of Plan You are Enrolling In:			
Name:		Contract Number	
Permanent Address: (Number, Street, Apartment Number)			
County:	City:	State:	Zip:
Telephone: (Area Code)			
Mailing Address: (if different from permanent address)			
County:	City:	State:	Zip:

Please fill out the following:

☐ I am currently a member of the _____ plan in _____ Blue Advantage with a monthly premium of $ _____.

☐ I would like to change to the _____ plan in _____Blue Advantage. I understand that this plan has different health benefits and a monthly premium of $_____.

Have you recently moved into this plan's service area?

☐ Yes ☐ No

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my Medicare Advantage plan coverage begins, I must get all of my health care from my new Medicare Advantage plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare Advantage plan and other services contained in my Medicare Advantage plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare Advantage plan.

Enrollee's Signature* _____ Date: _____

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign the following line. Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by state law.

Signature _____ Date: _____

*If anyone helped the beneficiary fill out this form, s/he must sign the following line:

Signature _____ Date: _____

Relationship to Beneficiary: _____