Autauga, Baldwin, Bibb, Blount, Calhoun, Chilton, Elmore, Etowah, Jefferson, Lawrence, Limestone, Lowndes, Madison, Mobile, Montgomery, Morgan, Shelby, St. Clair and Walker Counties.

Blue Advantage®

Medicare Advantage Plan Application

Be sure to read the important disclosures listed on the back before completing this application. Please use black ink and print clearly. Keep the white copy for your records. Mail the blue top copy in the return envelope which is included in your packet, or send to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing
P.O. Box 2768
Birmingham, Alabama 35202-2768

BlueCross BlueShield of Alabama

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

PERSONAL INFORMATION

FOR OFFICE USE ONLY

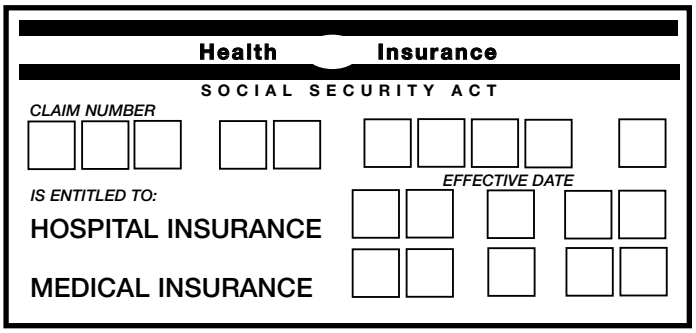
APPLICANT'S NAME (Last/First/Middle Initial)			**SEX** (check one) ☐ Male ☐ Female	
ADDRESS (Number & Street)	COUNTY	CITY	STATE	ZIP
MAILING ADDRESS (If different from permanent address)	COUNTY	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	DATE OF BIRTH	TELEPHONE (Area Code)
☐☐☐-☐☐-☐☐☐☐	**Month** | **Day** | **Year**	( ) _____ -_____

MEDICARE INFORMATION

- Fill in these blanks so they match your Medicare card, or
- Attach a copy of your Medicare card or your Letter from the Social Security Administration or Railroad Board.

We cannot consider this enrollment form completed until you have given us this information.



BENEFIT SELECTION

Please choose which product you want to enroll in:

☐ Option I - monthly premium of $0

☐ Option II - monthly premium of $43

PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. ☐ **Yes** ☐ **No**

Note: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Medicare Advantage organization as a commercial member or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. If 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. Have you recently moved into this plan's service area? ☐ **Yes** ☐ **No**

Your answer to the following questions will not keep you from enrolling in this plan.

3. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ **Yes** ☐ **No**

If yes, Name of Institution: _____

Address of Institution (number and street): _____

Phone Number of Institution: _____

Your Date of Admission into Institution: _____

4. Do you receive Medicaid benefits? ☐ **Yes** ☐ **No**

If **yes**, Medicaid Number: _____

5. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits? ☐ **Yes** ☐ **No**

If **yes**, what kind of insurance do you have? _____

What is the name of your insurance? _____

6. Do you or your spouse work? ☐ **Yes** ☐ **No**

PAYMENT INFORMATION

Please select ONE payment method. Premiums are payable in advance on a monthly basis. Note: It may take up to 60 days to implement bank draft. If so, you will receive a bill for your second month's premium.

☐ **Bank Draft** - submit application with a check payable to Blue Cross and Blue Shield of Alabama for your first month's premium. Please attach a completed Authorization Agreement for Bank Draft with a blank voided check.

☐ **Billing Statement**

☐ **Credit Card** or **Debit Card** - submit application with a check payable to Blue Cross and Blue Shield of Alabama for your first month's premium. Please attach a completed Authorization Agreement for Credit Card Payments.

IMPORTANT: Read the back of the Enrollment Form and sign below.

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.

Your Signature* _____ Date: _____

* If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law; or another person who is authorized by State law, must sign the following line. **Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law.**

Signature _____ Date: _____

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

Signature _____ Date: _____ Relationship: _____

APPLICATION AGREEMENT

I understand that the following statements are a part of my contract with Blue Cross and Blue Shield of Alabama.

1. I understand that while the "effective date of coverage" as described in the **Lock-In** section below is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from any Medicare supplement plan, or Medigap or Medicare Select plan until I get the approval from the plan.
2. I understand that I must keep my Medicare Part A and Part B insurance by paying the Part B premiums and the Part A premiums, if applicable.
3. I understand that I can be a member of only one Medicare Advantage plan at a time. By enrolling in this plan, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member.
4. I understand that since I can be a member of only one Medicare Advantage plan at a time, I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage. If I do this, my enrollments may be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Advantage plan.
5. I understand that I may disenroll from this plan by sending a written request to the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

   Social Security Administration
   6401 Security Blvd., Room 4 C-5 Annex
   Baltimore, MD 21235
   Toll Free: 1 800 772-1213

   Railroad Retirement Board
   844 N. Rush St., 9th Floor
   Chicago, IL 60611-2092
   Toll Free: 1 800 808-0772

   Until the effective date of disenrollment, I must keep getting health care from the plan doctors.
6. I understand that as a member of the plan, I have the right to ask about the plan's decision about payment or services if I disagree.
7. I understand that it is my job to tell the plan before I move out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me.

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 the 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 organization 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.