PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining ***Blue Advantage*** could affect your employer or union health benefits. If you have health coverage from an employer or union, joining ***Blue Advantage*** may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, 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.

APPLICATION AGREEMENT

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

Blue Advantage is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time.

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to ***Blue Advantage*** or by calling 1-800-Medicare. TTY users should call 1-877-486-2048. ***Blue Advantage*** serves a specific service area. If I move out of the area that ***Blue Advantage*** 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 ***Blue Advantage***, I have the right to appeal plan decisions about payment or services if I disagree.

I will read the Evidence of Coverage from ***Blue Advantage*** 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 that ***Blue Advantage*** coverage begins, I may get my heatlh care from providers that participate in ***Blue Advantage***, or from providers that do not participate in ***Blue Advantage***. I understand that if I use providers that do not participate in ***Blue Advantage***, my out-of-pocket cost may be higher than if I receive services from providers who participate in ***Blue Advantage***. If I use providers that do not participate in ***Blue Advantage*** for emergency care, urgently needed services, or for out-of-area dialysis services, my out-of-pocket cost would be the same as it would be if I used ***Blue Advantage*** providers.

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. 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 ***Blue Advantage*** or by Medicare.

Autauga, Baldwin, Bibb, Blount, Calhoun, Chilton, Elmore, Etowah, Jefferson, Lawrence, Limestone, Lowndes, Madison, Mobile, Montgomery, Morgan, Shelby, St. Clair or 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
Fax Number: 1 888-246-0230

BlueCross BlueShield of Alabama

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

FOR OFFICE USE ONLY

PERSONAL INFORMATION

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

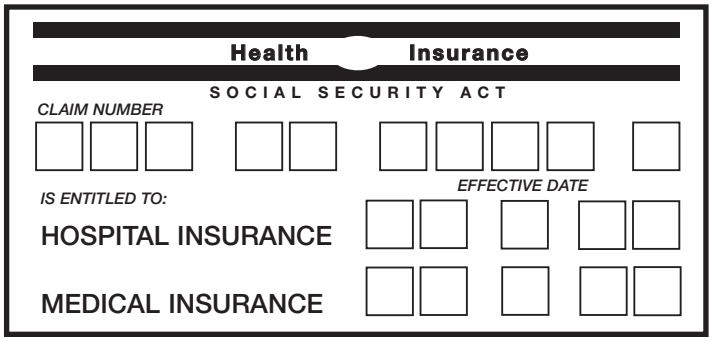
SOCIAL SECURITY NUMBER	DATE OF BIRTH	TELEPHONE (Area Code)
☐☐☐-☐☐-☐☐☐☐	**Month** / **Day** / **Year**	( ) _____ -_____

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.

You must have Medicare Part A and B to join a Medicare Advantage plan.

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 $38.00
- ☐ **Option III** monthly premium of $43.00
- ☐ **Option IV** monthly premium of $59.00
- ☐ **Option V** monthly premium of $73.00

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 long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

If yes, please provide the following information:

Name of Institution: _____

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

_____

Your Date of Admission into Institution: _____

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

If **yes**, Medicaid Number: _____

5. 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 ***Blue Advantage?*** ☐ **Yes** ☐ **No**

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

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____

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.

☐ **Social Security Administration Check** - You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or one of the methods above. Generally you must stay with the option you choose for the rest of the year.If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Choose this option if you want the remaining premium, if there is any, deducted from your monthly check.

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: _____