Connecticut | Massachusetts
Rhode Island | Vermont

Blue MedicareRx (PDP) 2024

ENROLLMENT FORM

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the United States
- Live in the plan's service area

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within three 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.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

What happens next?

Send your completed and signed form to:

Blue MedicareRx
P.O. Box 30001
Pittsburgh, PA 15222-0330

Once we process your request to join, we'll contact you.

Contact Us:

Connecticut Residents:

1-866-832-9702 (TTY: **711**)
24 hours a day, 7 days a week

Massachusetts Residents:

1-800-678-2265 (TTY: **711**)
10/1-3/31, 8:00 a.m. to 8:00 p.m., 7 days a week;
4/1-9/30, 8:00 a.m. to 8:00 p.m., Monday through Friday

Rhode Island Residents:

1-800-505-2583 (TTY: **711**)
10/1-3/31, 8:00 a.m. to 8:00 p.m., 7 days a week;
4/1-9/30, 8:00 a.m. to 8:00 p.m., Monday through Friday
You can use our automated answering system outside of these hours.

Vermont Residents:

1-888-496-4178 (TTY: **711**)
24 hours a day, 7 days a week

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

S2893_2317_C OMB No. 0938-1378 Expires:7/31/2024

Section 1 – All fields on this page are required (unless marked optional) 2024

Select the 2024 plan you want to join:

❑ Blue MedicareRx Value Plus: $53.40 per month

❑ Blue MedicareRx Premier: $155.80 per month

FIRST name:	LAST name:	MIDDLE initial (optional):
Birth date: (MM/DD/YYYY) (__ __ __ __ __ __ __ __)	Sex: ❑ Male ❑ Female	Phone number: ( ) -

Permanent Residence street address (Don't enter a PO Box):

Street address:	City:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address:	City:	State:	ZIP Code:

Email (optional):

By providing your email, you're opting in to receiving your plan materials digitally. You can opt out at any time.

Your Medicare information:

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE®) in addition to Blue MedicareRx? ❑ Yes ❑ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

IMPORTANT: Read and sign below:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Blue MedicareRx.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Blue MedicareRx 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).
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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'll 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 United States border.
- 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:	Phone number:
Street address:	Relationship to enrollee:

Section 1A – Enrollment Eligibility 2024

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between October 15 and December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period. Please read the below statements carefully and check the box if the statement applies to you. By checking any of the following boxes you're certifying that, to the best of your knowledge, you're eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled. **Please check all that apply and include applicable dates in the designated space for each section.**

❑ I'm applying during the Annual Enrollment period (October 15 through December 7) for an effective date of January 1.

Medicare Assistance Programs

❑ I recently had a change in my Medicaid (new recipient of Medicaid; had a change in level of Medicaid assistance; or lost Medicaid) on:

❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (new recipient of Extra Help; had a change in the level of Extra Help; or lost Extra Help) on:

❑ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I receive Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. I'm making this enrollment request between January 1 and September 30 and I understand I can only make this request once per quarter.

❑ I belong to a pharmacy assistance program provided by my state.

❑ I recently left a PACE program on:

❑ I live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on:

Insert Date: (__ __ __ __ __ __ __ __)
(M M / D D / Y Y Y Y)

Change in Residence

❑ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on:

❑ I recently returned to the United States after living permanently outside of the United States. I returned to the United States on:

❑ I recently obtained lawful presence status in the United States. I received this status on:

❑ I recently was released from incarceration. I was released on:

Insert Date: (__ __ __ __ __ __ __ __)
(M M / D D / Y Y Y Y)

I'm new to Medicare.

❑ 65th Birthday

❑ Disability Determination

❑ Existing Medicare (via disability)–now turning 65

Insert Date: (__ __ __ __ __ __ __ __)
(M M / D D / Y Y Y Y)

I involuntarily lost coverage.

❑ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's) on:

❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan on:

Insert Date: (__ __ __ __ __ __ __ __)
(M M / D D / Y Y Y Y)

Miscellaneous reasons

❑ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan.

❑ I was affected by an emergency or major disaster (as directed by the Federal Emergency Management Agency (FEMA) or by a federal, state, or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

❑ I'm leaving employer or union group coverage on:

❑ I'm enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) between January 1 and March 31.

❑ Individuals Enrolled in a plan placed in receivership

❑ Individuals Enrolled in a plan that has been identified by Centers for Medicare & Medicaid Services (CMS) as a Consistent Poor Performer

Insert Date: (__ __ __ __ __ __ __ __)
(M M / D D / Y Y Y Y)

Other

❑ Other Explain: _____

If none of these statements apply to you or you're not sure, please contact us to see if you're eligible to enroll.

Section 2 – All fields on this page are optional. 2024

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or of Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or of Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a, or of Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **I choose not to answer.**

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native

Asian:

- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian

- ❑ Black or African American

Native Hawaiian and Pacific Islander:

- ❑ Guamanian or Chamorro
- ❑ Hawaiian
- ❑ Samoan
- ❑ Other Pacific Islander

- ❑ White
- ❑ **I choose not to answer.**

Select if you want us to send you information in an accessible format. ❑ Large print ❑ Braille ❑ Audio CD

Please contact Blue MedicareRx at the phone number listed on the front page if you need information in an accessible format other than what is listed above.

Do you work? ❑ Yes ❑ No

Does your spouse work? ❑ Yes ❑ No

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

Paying your plan premiums

You can pay your monthly plan premium by mail, electronic funds transfer (EFT), which is an automatic withdrawal from your bank account, or credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Blue MedicareRx the Part D-IRMAA.

Please select a premium payment option:

- ❑ Receive a bill

Automatic deduction from your monthly ❑ Social Security or ❑ Railroad Retirement Board benefit check

- ❑ Automatic Bank Draft Withdrawal from Checking or Savings Account

Please send us a VOIDED check and fill in the requested information, which allows us to deduct your monthly premium payment from your bank account. ❑ **Checking** ❑ **Savings (check one)**

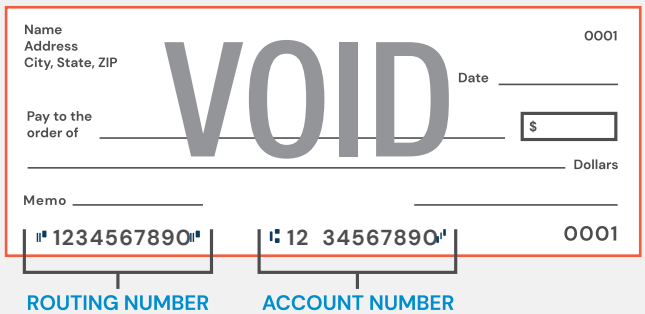
Name on Account

Financial Institution

Routing Number **Account Number**

Account Holder Signature _____

The Account Holder Signature is required in order to deduct premiums from Checking or Savings Account.



By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization named above to pay my premium through electronic bank withdrawal payable to Blue MedicareRx. I authorize the deduction of up to $300 at a time (only if the balance is such). The bank or other financial organization will be fully protected in honoring these payments until notice from me canceling this request is received.

Note: The option to pay using a credit card will be included on your monthly invoice. You can also call us toll free once your enrollment in the plan is active.

Broker Box for Connecticut and Rhode Island Only: 2024

Medicare Prescription Drug Plan Office and Producer Use Only:

Date Application Received by Agent/Broker/Rep: _____

Effective Date of Coverage: _____

Enrollment Period Type: ❑ IEP ❑ AEP ❑ SEP

Agent Individual Writing Code: _____

Agent/Broker/Rep Name: _____

Agent/Broker/Rep Signature: _____

Agent/Broker/Reps Only – please fax the completed application to the following number within 24 hours of receipt:

Connecticut: **1-866-342-7048** Rhode Island: **1-401-459-5025**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Don't send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It won't be kept, reviewed, or forwarded to the plan. See "What happens next?" on the first page of this document when you send your completed form to the plan.

Blue MedicareRx (PDP) is a Prescription Drug Plan with a Medicare contract. Blue MedicareRx Value Plus (PDP) and Blue MedicareRx Premier (PDP) are two Medicare Prescription Drug Plans available to service residents of Connecticut, Massachusetts, Rhode Island, and Vermont.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

You can file a complaint if you feel that you received inaccurate, misleading, or inappropriate information. Please call Customer Care at the number on the front page of this form (TTY users call: **711**). If your complaint involves a broker or agent, be sure to include the name of the broker/agent when filing your complaint.

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 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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.