

INSTRUCTIONS: Please complete A through D of this form.
Sign and date where indicated.
Return completed form to your Group's benefits administrator.
Please read each statement in sections E & F.



**BlueCross BlueShield
of Illinois**

A. Personal Information (please print clearly)

Retiree's Employer Name			Group Number Section Number	
Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date: (MM/DD/YYYY) (__/__/____)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security # (optional)		
Work Phone #: ()	Home Phone #: ()			

Permanent Residence Address:

Street: _____ City: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Street: _____ City: _____ State: _____ ZIP Code: _____

B. Medicare Information: Copy information exactly as it appears on your Medicare card

First Name:	Middle Initial:	Last Name:
Medicare Claim (ID) No. (include alpha characters)		
Is entitled to:		
HOSPITAL (Part A)		MEDICAL (Part B)
Effective Date (MM/DD/YYYY) (__/__/____)		Effective Date (MM/DD/YYYY) (__/__/____)

C. Please read and answer these important questions

Coverage is subject to eligibility requirements as defined by the above employer and subject to Blue Cross and Blue Shield of Illinois guidelines.

1. Are you the retiree of the above employer? Yes No
 If "yes", retirement date (MM/DD/YYYY) (__/__/____)
 If "no", name of retiree: _____

2. If you are the retiree of the above employer, are you also applying for coverage for a spouse or dependents under the above employer's plan? Yes No
 If "yes", please complete a separate enrollment form for each individual.
 Name of spouse: _____
 Name of dependents: _____

C. Please read and answer these important questions (continued from previous page)

3. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage (creditable coverage) since you became eligible to join a Medicare drug plan? Yes No

If no, you may have to pay a penalty. Blue MedicareRx may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have questions about the late enrollment penalty, call Blue MedicareRx at (877) 838-3833 between 8 a.m. - 8 p.m., CT. For the hearing or speech impaired, please call (800) 693-3816.

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.

4. Will you have other prescription drug coverage in addition to Blue MedicareRx? Yes No
If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Company Name(s) of other coverage: _____

ID number(s) for this coverage: _____

Group(s) number for this coverage: _____

Effective date of other RX coverage: (MM/DD/YYYY) (___ / ___ / _____)

5. Typically, you may only enroll in a Medicare Prescription Drug Plan during the annual open enrollment period each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual open enrollment period.

Please read the following statements and check EACH box that applies to you. Blue MedicareRx will contact you if additional information is required. If none of these statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll.

I am new to Medicare.

I recently moved outside of my current Medicare health plan’s or Medicare prescription drug plan’s service area.

I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

I was recently approved for extra help paying for Medicare prescription drug coverage.

I just moved into a Long Term Care Facility (for example, a nursing home or longer term care).

Date of Move (MM/DD/YYYY) (___ / ___ / _____)

I recently left a PACE program.

I recently involuntarily lost my coverage that is at least as good as Medicare’s (also referred to as “creditable coverage”).

6. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If “yes” please provide the Name of the Institution: _____

Address (number, street, city and state) and phone number of institution: _____

D. Please read section F and sign below:

I understand that my signature** on this application means that I have read and understand the contents of this application including the information in section F of this form. 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.

Applicant or Guardian/Authorized representative

** Signature: _____ Date: _____

Requested Effective Date: _____ (Please note that enrollment rules may not allow for us to accommodate your requested effective date. Your enrollment confirmation letter will include your actual effective date.)

**Or that of a person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by another individual, the signature certifies that the person is authorized under State law to complete this enrollment and that documentation of this authority is available upon request by Blue MedicareRx or by Medicare.

If you are the Guardian/Authorized representative, you must provide the following information:

Name: _____

Address: _____

Telephone Number: () _____ Relationship to Applicant: _____

Check if Applicant received assistance in completing this form. The person who assisted must sign below.

Signature: _____

Date: _____ Relationship to Applicant : _____

To be completed by agent/broker

Agent Name (Print): _____

Agent Number: _____ Agency Number : _____

Agent Signature: _____

Date: _____ Telephone Number: () _____

E. STOP — Please Read This Important Information — STOP

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Blue MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverages as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

F. Enrollment Authorization

Please read carefully and sign on the appropriate line in section D after reading all statements in this section. Keep a copy for your records.

1. I understand Blue MedicareRx is a regional Medicare Prescription Drug plan with a Medicare contract.

F. Enrollment Authorization *(continued from previous page)*

2. I understand Blue MedicareRx is a Medicare Prescription Drug plan and is in addition to my coverage under Medicare Part A and B; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Blue MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug plan at a time. Enrollment in the plan is generally for the entire year.
3. I understand I may **disenroll** from Blue MedicareRx only at certain times of the year, or under certain special circumstances, by sending a request to Blue MedicareRx or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
4. I understand that Blue MedicareRx coverage serves a specific service area. If I move out of the service area, I must notify the plan so I can disenroll and find a new plan in my area.
5. I understand that once I am a member of Blue MedicareRx, I have **the right to appeal Blue MedicareRx decisions** about payment or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx when I receive it to know the rules I must follow in order to receive coverage with this Medicare drug plan. I understand that Blue MedicareRx will send me final approval of my enrollment in the plan.
6. I understand that I should not disenroll from any Medicare Supplement plan, or Medigap or Medicare Select plan until I get that approval form Blue MedicareRx.
7. I understand by joining this Medicare Prescription Drug plan, I acknowledge that Blue MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
8. I understand that if I obtain prescriptions outside the Blue MedicareRx network, I will be subject to out-of-network copayments or coinsurances.
9. I understand that if I am working with an agent/broker who is either employed by or contracted with the independent Blue Cross and Blue Shield plans offering Blue MedicareRx the person may be compensated based on my enrollment plan.
10. I am a retiree or a spouse or dependent of the retiree of the above employer. I am eligible to participate in the coverage(s) afforded by such employer's plan, which is either underwritten or administered by HCSC Insurance Company. I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).
11. I authorize necessary payroll, pension or other similar deductions by my employer, if any, to cover the cost of my coverage(s). I agree that the employer acts as my agent. All notices given to the Employer are binding upon me.

Blue Cross and Blue Shield of Illinois refers to HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Part D products under HCSC Insurance Services Company's contract number S5715 with the Centers for Medicare and Medicaid Services.

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