2017 BCN Advantage℠ Core Application

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

To enroll in BCN Advantage HMO-POS Core, please complete the following form:

We're here to help.

- Need help completing your application?
- Want more information?
- Have questions?
- Interested in finding an independent agent licensed to sell Blue Cross?

Please call us at **1-888-563-3307**. Our hours are 8 a.m. to 9 p.m., Monday through Friday with weekend hours Oct. 1 through Feb. 14. **TTY users should call 711**.

Ready to enroll in BCN Advantage HMO-POS?
Enroll online by visiting: **www.bcbsm.com/medicare** or The Centers for Medicare and Medicaid Services Online Enrollment Center at **www.medicare.gov/find-a-plan**.

OR

Enroll using this form. Here are some helpful hints:

- Use a black or blue ink pen.
- Complete a separate form for each person enrolling.
- If you need another copy, make a photocopy or call us.
- Print your answers, except where your signature is required; that's on page 7.
- Make sure you complete each section of the application.
- Mail your application promptly.

Please do not send your payment with this application. Just keep the yellow copy for your records and return the completed form in the postage-paid envelope, or mail it to:

BCN Advantage HMO-POS
Mail Code H300
P.O. Box 5013
Southfield, MI 48086-9719

What happens next?

- We'll call to make sure you know how this plan works and that you want to enroll. If we can't reach you by telephone, we'll send a letter that explains this.
- Once CMS approves your application, we'll send you a letter within 10 days, confirming your enrollment.
- We'll bill you based on your plan choice (or automatically deduct your premium if you choose that option).
- You'll also receive an information packet about your benefits and the extras you get with your Blue Cross coverage.

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

2017 INDIVIDUAL ENROLLMENT FORM Medical Coverage (Coverage effective 2017)

Office use only:

Please contact BCN Advantage HMO-POS at **1-888-563-3307** if you need information in another format or to be referred to our foreign language line. **TTY users should call 711**. Call center hours are 8 a.m. to 9 p.m., Monday through Friday; with weekend hours Oct. 1 through Feb. 14.

Sec. 1 To enroll in BCN Advantage HMO-POS Core plan, please complete following information.

The HMO-POS Core plan premium is: ☐ **$20**

☐ Mr. ☐ Mrs. ☐ Ms.	First name	Middle initial	Last name

Birth date	Sex ☐ Male ☐ Female	Daytime phone number	Alternate phone number

Permanent residence street address *(no P.O. box)*	City	State

ZIP code	County	Email address *(optional)*

Mailing address *(only if different from your permanent residence street address)*

Street address		

City	State	ZIP code

OPTIONAL INFORMATION

Emergency contact name	

Relationship to you	Phone number

Sec. 2 Please provide your Medicare insurance information.

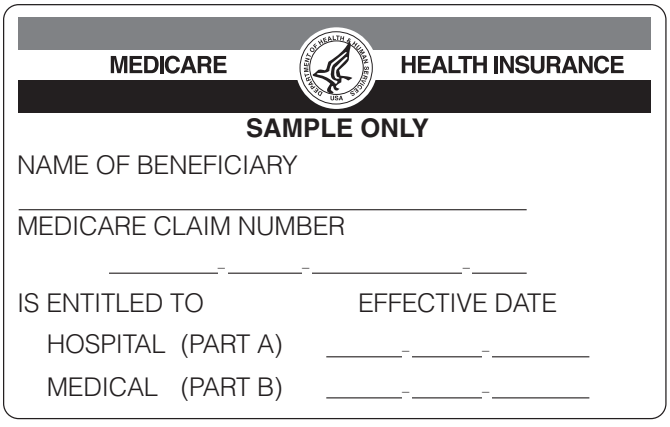
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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



Sec. 3 Please read the following statements and check the box that applies to you.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are confirming that, to the best of your knowledge, you are eligible for an enrollment period. If we find that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare (effective date: ____ /____ /____).
- ☐ I am enrolling during the annual enrollment period (between October 15 and December 7).
- ☐ 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 (insert date: ____ /____ /____).
- ☐ I recently was released from incarceration. I was released on (insert date: ____ /____ /____).
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date: ____ /____ /____).
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums (insert date: ____ /____ /____).
- ☐ I live in a long-term care facility (for example, a nursing home or rehabilitation hospital).
- ☐ I recently left a PACE® program on (insert date: ____ /____ /____).
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date: ____ /____ /____).
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date: ____ /____ /____).
- ☐ I am leaving/losing employer or union coverage on (insert date: ____ /____ /____).
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date: ____ /____ /____).
- ☐ I get extra help paying for Medicare prescription drug coverage, but do not have Medicaid.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date: ____ /____ /____).
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan (effective date: ____ /____ /____).
- ☐ I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
- ☐ I was enrolled in a SNP (or Special Needs Plan) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date: ____ /____ /____).
- ☐ Other

If none of these statements apply to you or you are uncertain, please contact BCN Advantage at **1-888-563-3307 (TTY users should call 711)** to see if you are eligible to enroll. We are open 8 a.m. to 9 p.m., Monday through Friday; with weekend hours Oct. 1 through Feb. 14.

Sec. 4 Paying your plan premium

You can pay your monthly plan premium (including any late enrollment fee that you may owe) by mail, electronic funds transfer or an automatic withdrawal from your bank account. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you're assessed a Part D-Income related Monthly Adjustment Amount (Part D-IRMMA), you'll be notified by the Social Security Administration. You'll be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **Do not** pay the Part D-IRMAA to BCN Advantage HMO-POS.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also apply for extra help online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we'll bill you for the amount that Medicare doesn't cover. **If you don't select a payment option, you'll get a bill each month. You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check. If you select a BCN Advantage plan with a monthly premium over the Social Security limit, the premium can't be taken out of your Social Security check. Instead, you must pay your premium directly to us. We encourage you to enroll in our electronic funds transfer so you don't have to receive a monthly statement or write a check. Choose automatic deductions if you don't want to get a statement each month**.

Please select a premium payment option:

☐ Electronic funds transfer from your bank account each month. Please allow three to four weeks to process your application. Please pay any premium bill you may receive while your application is processing. Future monthly premiums will be automatically withdrawn from your specified account on the **fifth** day of every month.

Please enclose a VOIDED check:

Account holder name: _____

Bank routing number: _____
(first set of numbers located on left side of check)

Bank account number: _____
(second set of numbers located in the center of check)

Account type: ☐ Checking ☐ Savings

☐ Get a bill on a monthly basis. You may choose from the following payment methods:

Pay online: To learn how to pay your premium online, go to **www.bcbsm.com/ebilling**.

Pay by phone: You can call **1-855-321-5346**, 24 hours a day, seven days a week, or call BCN Advantage Customer Service at **1-800-450-3680**, 8 a.m. to 9 p.m., Monday through Friday, with weekend hours Oct.1 through Feb.14. **TTY users, call 711**.

Pay by mail: Mail your check, cashier's check or money order made payable to Blue Care Network directly to **Blue Care Network, P.O. Box 33608, Detroit, MI 48232-5608**.

Sec. 4 *continued* **Paying your plan premium**

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/ Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board doesn't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums.)

Sec. 5 **Please read and answer these important questions**

1. Please choose a Primary Care Physician (PCP). Please note that not all Blue Care Network providers are contracted with BCN Advantage. Please verify that your PCP is contracted with BCN Advantage.

   Name of PCP: _____ City: _____

   Are you a current patient of this doctor? ☐ **Yes** ☐ **No**

2. Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or state pharmaceutical assistance programs.

   Will you have additional medical or prescription drug coverage in addition to BCN Advantage HMO-POS?

   ☐ **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: _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**
   If "yes," please provide the following information:

Name of institution		Address	
City	State	ZIP code	Phone number

4. Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you for additional information.
5. Are you enrolled in your state Medicaid program? ☐ **Yes** ☐ **No**

   If "yes," please provide your Medicaid number: _____
6. Do you or your spouse work? ☐ **Yes** ☐ **No**

Please contact BCN Advantage HMO-POS at **1-888-563-3307** with questions, if you need information in another format or to be referred to our foreign language line. **TTY users should call 711**. Call center hours are 8 a.m. to 9 p.m., Monday through Friday.

Sec. 6 **Please read this important information**

If you currently have health coverage from an employer or union, joining BCN Advantage HMO-POS could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCN Advantage HMO-POS . 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

- BCN Advantage HMO-POS is a Medicare Advantage plan and has a contract with the federal government. I need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It's my responsibility to tell you about any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.
- BCN Advantage HMO-POS serves a specific area. If I move out of the area that BCN Advantage HMO-POS 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 BCN Advantage HMO-POS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document (also known as a member contract or subscriber agreement) from BCN Advantage HMO-POS when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out-of-the-country except for limited coverage near the U.S. border.
- I understand that beginning on the date BCN Advantage HMO-POS coverage begins, I must get all of my health care from BCN Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCN Advantage HMO-POS and other services contained in my BCN Advantage HMO-POS Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BCN ADVANTAGE HMO-POS WILL PAY FOR THE SERVICES**.
- I understand that if I get help from a sales agent, broker or other individual employed by or contracted with BCN Advantage HMO-POS, he/she may be paid based on my enrollment in BCN Advantage.

Release of Information:

By joining this Medicare health plan, I acknowledge that BCN Advantage HMO-POS will release my information to Medicare and other plans as needed for treatment, payment and health care operations. I also acknowledge that BCN Advantage HMO-POS will release my information including my prescription drug data to Medicare, who may release it for research or other purposes that follow all applicable federal statutes and regulations. 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.

Sec. 6 *continued* **Please read and sign below**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the content 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 from Medicare.

Signature	Date

If you are the authorized representative of the enrollee, you must sign above and provide the following information:

Name		Phone	
Street address	City	State	ZIP code
Relationship to applicant			

AGENT/OFFICE USE ONLY (Applicants do not complete this section)

Note to producing agents: *2017 paper enrollment forms must be keyed into* ***http://www.bcbsm.com/agents/help/faqs/medicare-enrollment-faq.html*** *or submitted to the managing or general agent within 24 hours of accepting the paper enrollment form.*

Date producing agent accepted paper enrollment from Medicare eligible: / /

Date managing or general agent or association received paper enrollment form from producing agent: / /

Name of managing/general agent or association: _____

Name of producing agent (print first/last names): _____ _____

First name *Last name*

Signature of producing agent: _____

Email of producing agent: _____

2-digit managing or general agent or association code:

5-digit producing agent code:

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ **Yes** ☐ **No**

Name of person entering enrollment information online (print first/last names): _____ _____

First name *Last name*

Please note: Not all BCN providers are contracted with BCN Advantage. Please verify that the primary care physician listed in this form is contracted with BCN Advantage by calling **1-888-563-3307**. **TTY users should call 711**.

Be sure to have the member complete Section 3 and 5 in their entirety. Return this form to:

BCN Advantage HMO-POS
Mail Code H300
P.O. Box 5013
Southfield, MI 48086-9719