

P.O. Box 45296, Jacksonville, FL 32232-5296

A Medicare Advantage Health Care Plan for Groups

## Employer/Union Group Health Plan Enrollment Form

**Please check a Health and Prescription drug plan option:**

Advanced PPO with Advanced Rx     Platinum PPO with Platinum Rx     Elite PPO with Elite Rx

Include dental/hearing/vision package:  Yes  No

Full Name of Employer or Union:

**CITY OF TALLAHASSEE**

Group #: <b>45380</b>	Location Code:  _ _ _ _	Group Renewal Date: <b>0 1   0 1   2 0 2 6</b>
--------------------------	----------------------------	---

Requested Effective Date of Coverage:  _ _ _ _ _ _ _	Employee ID # (if available):
---	-------------------------------

First Name:	Last Name:	Middle Initial:
-------------	------------	-----------------

Birth Date:  _ _ _ _ _ _ _	Sex: <input type="radio"/> M <input type="radio"/> F	Home Phone Number: (    )	Mobile Phone Number: (    )
-------------------------------	---	------------------------------	--------------------------------

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code:
-------	---------	--------	-----------

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

Street Address:	City:	State:	ZIP Code:
-----------------	-------	--------	-----------

By providing a telephone number(s), you confirm that you are the subscriber and/or authorized user of the phone numbers, provided and you consent to receive calls and text messages at those number(s) from, and on behalf of, Blue Cross and Blue Shield of Florida, Inc., Florida Blue Medicare, Inc., and their affiliates, including calls and texts using an automated telephone dialing system, prerecorded or artificial voice messages, or both. The types of calls and texts you consent to receive include messages about your plan and benefits, messages about servicing your account, and healthcare-related and informational messages that are not for marketing purposes. You may revoke your consent at any time. Message and data rates may apply. Message frequency varies. Major carriers supported. Our Terms of Use and Privacy Policy also apply and are available online at [floridablue.com](http://floridablue.com).

**Please provide your Medicare insurance information:**

Please take out your red, white and blue Medicare card to complete this section.

Medicare Number:	Part A Effective Date:  _ _ _ _ _ _ _	Part B Effective Date:  _ _ _ _ _ _ _
------------------	--	--

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

Language:  Spanish

Accessible Format (Select One):  Braille  Large Print  Audio CD  Data CD

Please contact BlueMedicare Group PPO at 1-800-926-6565 if you need information in an accessible format or language other than what is listed above. TTY users should call 1-800-955-8770. Our hours are 8 a.m. to 8 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Please read and answer these important questions:

1. Are you a retiree?  Yes  No

If "yes," retirement date?:

If "no," name of retiree: \_\_\_\_\_

2. Are you covering a spouse or dependent(s) under this employer or union plan?  Yes  No

If "yes," name of spouse: \_\_\_\_\_

Name(s) of dependent(s): \_\_\_\_\_

\_\_\_\_\_

3. Do you or your spouse work?  Yes  No

4. Will you have other **prescription** drug coverage in addition to BlueMedicare Group PPO?  Yes  No

If "yes," please provide the following information:

Name of Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Type of Coverage:

Group  Supplemental  Excess  Private (self pay)  Veterans Affairs (VA)

ID#: \_\_\_\_\_ Group# (if applicable): \_\_\_\_\_ Effective Date: \_\_\_\_\_ Term Date: \_\_\_\_\_

5. Will you have other **health** coverage in addition to BlueMedicare Group PPO?  Yes  No

If "yes," please provide the following information:

Name of Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Type of Coverage:

Group  Supplemental  Excess  Private (self pay)  Veterans Affairs (VA)

ID#: \_\_\_\_\_ Group# (if applicable): \_\_\_\_\_ Effective Date: \_\_\_\_\_ Term Date: \_\_\_\_\_

6. 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 of Institution (number and street): \_\_\_\_\_

Phone Number of Institution: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

7. Please provide the name of your Physician of Choice (POC), if applicable. A POC is a physician that you choose to see for most health reasons. If you wish to change to a different POC after becoming active in this plan, you may contact our Member Services Department.

POC First Name: _____	Physician Group Name: _____
POC Last Name: _____	Physician Group's FL Blue Provider ID Number  _ _ _ _ _ _ _ _ _ _  (ie: 12345 or 12345A)
POC's FL Blue Provider ID Number  _ _ _ _ _ _ _ _ _ _  (ie: 12345 or 12345A)	Physician Group's 10-digit National Provider ID (NPI) Number:  _ _ _ _ _ _ _ _ _ _
POC's 10-digit National Provider ID (NPI) Number:  _ _ _ _ _ _ _ _ _ _	Is enrollee currently a patient of this Physician Group? <input type="radio"/> Yes <input type="radio"/> No
Is enrollee currently a patient of this POC? <input type="radio"/> Yes <input type="radio"/> No	

If you are currently covered under a **Florida Blue Medicare Supplement** policy, do you intend to replace your current coverage with this new Florida Blue Medicare Advantage plan?  Yes  No

By checking here, you request Florida Blue to cancel your **Florida Blue Medicare Supplement** policy on the day before this Medicare Advantage plan becomes effective. For Example, Florida Blue BlueMedicare Group PPO plan is effective July 1st; Florida Blue will cancel your **Florida Blue Medicare Supplement** policy effective June 30th.

To ensure accurate processing, you must provide your **Florida Blue Medicare Supplement** Policy ID Number:

|H|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_| - |\_|\_|\_| (example: H12345678 - 01).

**Please Read and Sign Below. By completing this enrollment application, I agree to the following:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueMedicare Group PPO.
- I understand that my response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my BlueMedicare Group PPO coverage begins, I must get all of my medical and prescription drug benefits from BlueMedicare Group PPO. Benefits and services provided by BlueMedicare Group PPO and contained in my BlueMedicare Group PPO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueMedicare Group PPO will pay for benefits or services that are not covered.
- BlueMedicare Group PPO serves a specific service area. If I move out of the area that BlueMedicare Group PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area.



**Medicare Prescription Payment Plan Participation** (Completion of this section is optional.)

Yes, I would like to participate in the Medicare Prescription Payment Plan.

- I understand this section is a request to participate in the Medicare Prescription Payment Plan. BlueMedicare Group PPO will contact me if they need more information.
- I understand that signing below means I have read and understand this section and the "Terms and Conditions" below.
- BlueMedicare Group PPO will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active. Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

**Signature:**

\_\_\_\_\_

**Today's Date:**

--	--	--	--	--	--	--	--	--	--

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

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Relationship to Enrollee:** \_\_\_\_\_

**Terms and Conditions**

- The program is free to join, there are no fees or interest charged under the program, and the program does not lower the amount of cost-sharing you owe for your Part D prescriptions.
- If you qualify for Low Income Subsidy (LIS), enrollment in LIS is more advantageous than participation in the Medicare Prescription Payment Plan.
- You may opt out of the program at any time. If you opt out, you will still be responsible for paying any remaining balance.
- It is important to pay your bill monthly. Your participation in the Medicare Prescription Payment Plan will be terminated if you fail to pay your monthly billed amount before the end of the grace period.
- If you are disenrolled voluntarily or involuntarily from our Part D plan you will also be terminated from the Medicare Prescription Payment Plan. If you enroll in a different plan, you may opt into the Medicare Prescription Payment Plan under your new plan.
- We cannot require you to answer questions about or provide documentation to prove your ability to pay your Medicare Prescription Payment Plan balance as a condition of you participating in the Medicare Prescription Payment Plan. We also cannot obtain a copy of your credit report from a consumer reporting agency.
- The Part D appeals and grievance procedures will apply to the Medicare Prescription Payment Plan and are located in the Evidence of Coverage.

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_

Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_

AEP: \_\_\_\_\_

SEP (type): \_\_\_\_\_

Not Eligible: \_\_\_\_\_

Date Received by Agent: \_\_\_\_\_

Florida Blue Agent ID #: \_\_\_\_\_

Agent State License #: \_\_\_\_\_

Agent Confirmation #: \_\_\_\_\_