Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO), Blue Shield Vital (HMO), and Blue Shield Medicare (PPO) Short Enrollment Request Form

blue california

Please fax or mail your completed enrollment form to:
Fax: (877) 251-3660
Mail: Blue Shield of California, PO Box 948, Woodland Hills, CA 91365-9856

Name of Plan You are Enrolling in:

Name:

Member Number:

Home phone number:

- -

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

City State ZIP code

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

City State ZIP code

Please fill out the following:

I am currently a member of the

plan in

(Blue Shield of California) with a monthly premium of $_____.

I would like to change to the

plan in

(Blue Shield of California).

I understand that this plan has different health benefits and a monthly premium of $_____.

Please indicate if you would like to enroll in the Optional Supplemental Dental HMO or PPO plan

☐ Optional Supplemental Dental HMO plan ($11.60 per month)
(Dental plan option not available for Blue Shield 65 Plus in Santa Barbara/San Luis Obispo Counties) and Blue Shield Medicare in Alameda County.

Name of dentist

Provider ID#

If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

☐ Optional Supplemental Dental PPO plan ($37.90 per month)
No dentist selection necessary for the PPO plan.

Name of chosen Primary Care Physician (PCP):

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:

☐ Spanish ☐ Large Print

Please contact Blue Shield 65 Plus℠, Blue Shield 65 Plus℠ Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, or Blue Shield Medicare at **(800) 776-4466** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30. TTY users should call **711**.

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or by Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will 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 Railroad Retirement Board. Do NOT pay Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, or Blue Shield Medicare the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a late enrollment penalty payment option:

☐ Get a monthly bill.

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please fill out the Blue Shield Easy$Pay form if you're not already using EFT. If you do not have a copy of the form, please call us and we will send you one.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

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

Please Read This Important Information

Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare are plans that have a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare he/she may be paid based on my enrollment in Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare.

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. I also acknowledge that Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which 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. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare coverage begins, I must get all of my health care from Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan, Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare, except for emergency or urgently needed services or out-of-area dialysis services.

I understand that beginning on the date Blue Shield Medicare (PPO) coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary Blue Shield Medicare (PPO) provides refunds for all covered benefits, even if I get services out of network.

Services authorized by Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan,Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare and other services contained in my Blue Shield 65 Plus, Blue Shield 65 Plus Choice Plan,Blue Shield Trio Medicare, Blue Shield Inspire, Blue Shield Vital, and Blue Shield Medicare *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS, BLUE SHIELD 65 PLUS CHOICE PLAN, BLUE SHIELD TRIO MEDICARE, BLUE SHIELD INSPIRE, BLUE SHIELD VITAL, AND BLUE SHIELD MEDICARE WILL PAY FOR THE SERVICES**.

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 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 from Medicare.

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:

Producer information: Producer name and ID or NPN **is required**.

FMO/Agency name: Steve Shorr Insurance
(please print appointed agency name)

FMO/Agency ID #: _____
(please print agency ID)

Producer ID #: 8914
(please print agent ID number or NPN)

Producer NPN #: 2710578
(please print NPN number)

Producer Name: Steve Shorr
(please print writing agent name)

Producer Phone Number: 310.519.1335

Producer Email Address: Steve@SteveShorr.com

Date application was received by producer: _____

Producer signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.