

2015 Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO  
Enrollment Application

Residents of the following counties: Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties, [please click here](#).

Residents of the following counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Somerset, Venango and Warren counties, [please click here](#).

Residents of the following county: Cambria, [please click here](#).

Residents of the following counties: Bedford, Blair, Huntingdon and Potter counties, [please click here](#)

## ENROLLMENT APPLICATION



### INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

Please contact Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO at 1-866-682-7970 (TTY users should call 711) to inquire about materials on audio CD or for telephone translation services. Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

### WAYS TO ENROLL



**Mail:** Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Senior Markets  
Enrollment Department  
P.O. Box 535049  
Pittsburgh, PA 15253-9801



**Phone:** Complete your application over the phone toll-free at **1-866-682-7970** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.



**Online:** Complete your application online at **[www.highmarkbcbs.com/medicare](http://www.highmarkbcbs.com/medicare)**



**In person:** Bring your application to a Medicare Solutions Seminar or other authorized locations. Call the toll-free number to find a meeting in your area.

**Southwest**

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

I understand that Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO will notify me in writing of my confirmed effective date of enrollment in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO. I understand that, typically, my effective date will be the first of the month following the month in which Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO.

Keystone Health Plan West, Inc. is a HMO plan with a Medicare contract. Enrollment in Keystone Health Plan West, Inc. depends on contract renewal. Highmark Inc. is a PPO plan with a Medicare contract. Enrollment in Highmark Inc. depends on contract renewal.

Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO are Medicare Advantage Plans and have contracts with the Federal government. I will need to keep my Medicare Parts A and Part 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 is my responsibility to inform you of 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. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or 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 (RRB) benefit check each month.

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 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](http://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. 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 special circumstances.

Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO serve a specific service area. If I move out of the area that Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO serve, 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 Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO 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 the Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

I understand that beginning on the date Community Blue Medicare HMO or Security Blue HMO coverage begins, I must get all of my health care from Community Blue Medicare HMO or Security Blue HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Community Blue Medicare HMO or Security Blue HMO and other services contained in my Community Blue Medicare HMO or Security Blue HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR COMMUNITY BLUE MEDICARE HMO OR SECURITY BLUE HMO WILL PAY FOR THE SERVICES.**

I understand that beginning on the date Freedom Blue 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, Freedom Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in my Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM BLUE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO, he/she may be paid based on my enrollment in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO.

### **RELEASE OF INFORMATION:**

By joining this Medicare health plan, I acknowledge that Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO 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.

## PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Cross Blue Shield may use and disclose Protected Health Information for

payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Cross Blue Shield's Notice of Privacy Practices is available on Highmark Blue Cross Blue Shield's Web site, or from the Highmark Blue Cross Blue Shield Privacy Department.

## PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

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 RRB. DO NOT pay Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO the Part D-IRMAA.



AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Number:		Agency Number:

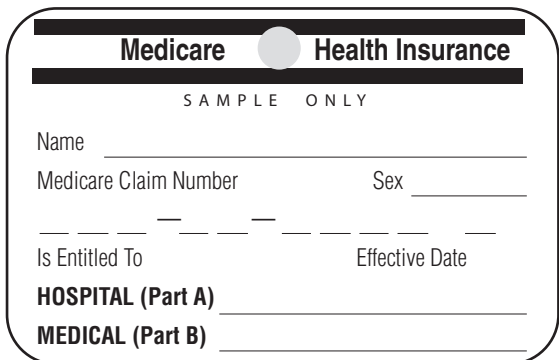
**TO ENROLL IN COMMUNITY BLUE MEDICARE HMO, SECURITY BLUE HMO OR FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (No P.O. Boxes)	Apt#	City	State	Zip
				County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip
				Date of Birth / /
Home Phone (with area code) ( )	Email Address (if applicable)			

**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 & Part B to join a Medicare Advantage Plan.

**PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:**

PLEASE MAKE ONLY ONE SELECTION

**Community Blue Medicare HMO**

Signature – \$0 per month  Prestige – \$193 per month

**Security Blue HMO**

Value – \$68 per month  Standard – \$205 per month

ValueRx – \$52 per month  Deluxe – \$279 per month

**Freedom Blue PPO**

ValueRx – \$123 per month  Classic – \$319 per month

Select – \$184 per month

**PAYING YOUR PLAN PREMIUM:**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) or on the web with eBill each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:**

Get a bill. Information about EFT and eBill will be included with your first bill.

Monthly  Quarterly  Semi-Annually  Annually

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

**OTHER INSURANCE**

1. Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield health plan? . . . . . Yes  No   
If YES, name of plan: \_\_\_\_\_
2. Will either you or your spouse be employed once enrolled in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO? . . . . . Self: . . . . . Yes  No   
Spouse: . . . . . Yes  No   
Your Retirement Date (Month/Day/Year): \_\_\_\_\_ Spouse's Retirement Date (Month/Day/Year): \_\_\_\_\_
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO or Medicare that will continue after your enrollment? Yes  No

**If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.**

**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 certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

**Annual Enrollment Period (October 15th through December 7th):**

If you are enrolling during the annual enrollment period from October 15th through December 7th of each year, and none of the options below apply, we will automatically process your enrollment as part of the Annual Enrollment Period – you do not need to fill out this page.

**NEW TO MEDICARE OR A CHANGE TO YOUR COVERAGE**

- I am new to Medicare.
- 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 employer or union coverage on \_\_\_\_\_ (insert date).
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

**RECENT 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 \_\_\_\_\_ (insert date).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on \_\_\_\_\_ (insert date).

**CHANGE IN INCOME OR SPECIAL NEEDS/PLAN QUALIFICATIONS**

- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on \_\_\_\_\_ (insert date).
- I belong to a pharmacy assistance program provided by my state.
- 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 was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on \_\_\_\_\_ (insert date).

If none of these statements applies to you or you're not sure, please contact Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO at 1-800-876-7639 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m.

**READ AND ANSWER THESE IMPORTANT QUESTIONS**

**Please choose the name of a Primary Care Provider (PCP), clinic or health center.**

Name of Provider (recommended)	PCP/NPI # (from the enclosed Provider Directory)
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The Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? (Confirmed enrollment in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.) .....Yes  No

Do you have End-Stage Renal Disease? .....Yes  No

If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark Blue Cross Blue Shield member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. 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 to obtain additional information.

Are you enrolled in your State Medicaid program? .....Yes  No

If "YES," please provide your Medicaid Number: \_\_\_\_\_

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 and Phone Number of Institution (number and street): \_\_\_\_\_

**STOP! Please read this important information. If you currently have health care coverage from an employer or union, joining Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO. Read the communications your employer or union sends you.**

**If you have questions, visit their Web site or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.**

**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 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 by Community Blue Medicare HMO, Security Blue HMO, Freedom Blue PPO, or by Medicare.

Signature	Today's Date
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If you are the authorized representative, you must sign above and provide the following information:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

**UPON RECEIPT OF YOUR APPLICATION, A COPY WILL BE RETURNED FOR YOUR RECORDS**

## ENROLLMENT APPLICATION



### INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

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Enrollment Department  
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**In person:** Bring your application to a Medicare Solutions Seminar or other authorized locations. Call the toll-free number to find a meeting in your area.

**West Central**

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://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. 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 special circumstances.

Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO serve a specific service area. If I move out of the area that Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO serve, 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 Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO 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 the Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

I understand that beginning on the date Community Blue Medicare HMO or Security Blue HMO coverage begins, I must get all of my health care from Community Blue Medicare HMO or Security Blue HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Community Blue Medicare HMO or Security Blue HMO and other services contained in my Community Blue Medicare HMO or Security Blue HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR COMMUNITY BLUE MEDICARE HMO OR SECURITY BLUE HMO WILL PAY FOR THE SERVICES.**

I understand that beginning on the date Freedom Blue 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, Freedom Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in my Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM BLUE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO, he/she may be paid based on my enrollment in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO.

### **RELEASE OF INFORMATION:**

By joining this Medicare health plan, I acknowledge that Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO 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.

## PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Cross Blue Shield may use and disclose Protected Health Information for

payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Cross Blue Shield's Notice of Privacy Practices is available on Highmark Blue Cross Blue Shield's Web site, or from the Highmark Blue Cross Blue Shield Privacy Department.

## PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

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 RRB. DO NOT pay Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO the Part D-IRMAA.



AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Number:		Agency Number:

**TO ENROLL IN COMMUNITY BLUE MEDICARE HMO, SECURITY BLUE HMO OR FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (No P.O. Boxes)	Apt#	City	State	Zip
				County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip
				Date of Birth / /
Home Phone (with area code) ( )	Email Address (if applicable)			

**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.

**PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:**

PLEASE MAKE ONLY ONE SELECTION

- |  |   |
|--|---|
| <b>Community Blue Medicare HMO</b>                 |   |
| <input type="checkbox"/> Signature – \$0 per month | <input type="checkbox"/> Prestige – \$193 per month |
| <b>Security Blue HMO</b>                           |   |
| <input type="checkbox"/> Value – \$64 per month    | <input type="checkbox"/> Standard – \$201 per month |
| <input type="checkbox"/> ValueRx – \$42 per month  | <input type="checkbox"/> Deluxe – \$237 per month   |
| <b>Freedom Blue PPO</b>                            |   |
| <input type="checkbox"/> ValueRx – \$105 per month | <input type="checkbox"/> Classic – \$280 per month  |
| <input type="checkbox"/> Select – \$137 per month  |   |

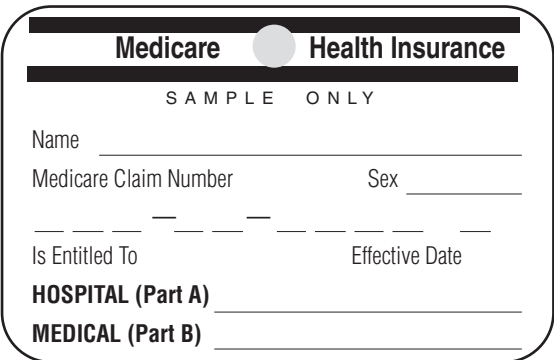
**PAYING YOUR PLAN PREMIUM:**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) or on the web with eBill each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:**

Get a bill. Information about EFT and eBill will be included with your first bill.

- Monthly  Quarterly  Semi-Annually  Annually
- Automatic deduction from your monthly Social Security or RRB benefit check. (The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.)



You must have Medicare Part A & Part B to join a Medicare Advantage Plan.

**OTHER INSURANCE**

1. Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield health plan? . . . . . Yes  No   
If YES, name of plan: \_\_\_\_\_
2. Will either you or your spouse be employed once enrolled in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO? . . . . . Self: . . . . . Yes  No   
Spouse: . . . . . Yes  No   
Your Retirement Date (Month/Day/Year): \_\_\_\_\_ Spouse's Retirement Date (Month/Day/Year): \_\_\_\_\_
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO or Medicare that will continue after your enrollment? Yes  No

**If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.**

**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 certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

**Annual Enrollment Period (October 15th through December 7th):**

If you are enrolling during the annual enrollment period from October 15th through December 7th of each year, and none of the options below apply, we will automatically process your enrollment as part of the Annual Enrollment Period – you do not need to fill out this page.

**NEW TO MEDICARE OR A CHANGE TO YOUR COVERAGE**

- I am new to Medicare.
- 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 employer or union coverage on \_\_\_\_\_ (insert date).
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

**RECENT 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 \_\_\_\_\_ (insert date).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on \_\_\_\_\_ (insert date).

**CHANGE IN INCOME OR SPECIAL NEEDS/PLAN QUALIFICATIONS**

- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on \_\_\_\_\_ (insert date).
- I belong to a pharmacy assistance program provided by my state.
- 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 was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on \_\_\_\_\_ (insert date).

If none of these statements applies to you or you're not sure, please contact Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO at 1-800-876-7639 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m.

**READ AND ANSWER THESE IMPORTANT QUESTIONS**

**Please choose the name of a Primary Care Provider (PCP), clinic or health center.**

Name of Provider (recommended)	PCP/NPI # (from the enclosed Provider Directory)
--------------------------------	--

The Community Blue Medicare HMO, Security Blue HMO and Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? (Confirmed enrollment in Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.) .....Yes  No

Do you have End-Stage Renal Disease? Yes  No

If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark Blue Cross Blue Shield member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. 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 to obtain additional information.

Are you enrolled in your State Medicaid program? .....Yes  No

If "YES," please provide your Medicaid Number: \_\_\_\_\_

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 and Phone Number of Institution (number and street): \_\_\_\_\_

**STOP! Please read this important information. If you currently have health care coverage from an employer or union, joining Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Community Blue Medicare HMO, Security Blue HMO or Freedom Blue PPO. Read the communications your employer or union sends you.**

**If you have questions, visit their Web site or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.**

**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 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 by Community Blue Medicare HMO, Security Blue HMO, Freedom Blue PPO, or by Medicare.

Signature	Today's Date
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If you are the authorized representative, you must sign above and provide the following information:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

**UPON RECEIPT OF YOUR APPLICATION, A COPY WILL BE RETURNED FOR YOUR RECORDS**

## ENROLLMENT APPLICATION



### INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

Please contact Security Blue HMO or Freedom Blue PPO at 1-866-682-7970 (TTY users should call 711) to inquire about materials on audio CD or for telephone translation services. Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

### WAYS TO ENROLL



**Mail:** Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Senior Markets  
Enrollment Department  
P.O. Box 535049  
Pittsburgh, PA 15253-9801



**Phone:** Complete your application over the phone toll-free at **1-866-682-7970** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.



**Online:** Complete your application online at **[www.highmarkbcbs.com/medicare](http://www.highmarkbcbs.com/medicare)**



**In person:** Bring your application to a Medicare Solutions Seminar or other authorized locations. Call the toll-free number to find a meeting in your area.

**Southwest**

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

I understand that Security Blue HMO or Freedom Blue PPO will notify me in writing of my confirmed effective date of enrollment in Security Blue HMO or Freedom Blue PPO. I understand that, typically, my effective date will be the first of the month following the month in which Security Blue HMO or Freedom Blue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in Security Blue HMO or Freedom Blue PPO.

Keystone Health Plan West, Inc. is a HMO plan with a Medicare contract. Enrollment in Keystone Health Plan West, Inc. depends on contract renewal. Highmark Inc. is a PPO plan with a Medicare contract. Enrollment in Highmark Inc. depends on contract renewal.

Security Blue HMO and Freedom Blue PPO are Medicare Advantage Plans and have contracts with the Federal government. I will need to keep my Medicare Parts A and Part 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 is my responsibility to inform you of 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. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or 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 (RRB) benefit check each month.

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 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](http://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. 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 special circumstances.

Security Blue HMO and Freedom Blue PPO serve a specific service area. If I move out of the area that Security Blue HMO and Freedom Blue PPO serve, 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 Security Blue HMO or Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Security Blue HMO or Freedom Blue PPO 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 the Security Blue HMO and Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

I understand that beginning on the date Security Blue HMO coverage begins, I must get all of my health care from Security Blue HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Security Blue HMO and other services contained in my Security Blue HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SECURITY BLUE HMO WILL PAY FOR THE SERVICES.**

I understand that beginning on the date Freedom Blue 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, Freedom Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in my Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM BLUE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Security Blue HMO or Freedom Blue PPO, he/she may be paid based on my enrollment in Security Blue HMO or Freedom Blue PPO.

### **RELEASE OF INFORMATION:**

By joining this Medicare health plan, I acknowledge that Security Blue HMO or Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Security Blue HMO or Freedom Blue PPO 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.

## PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Cross Blue Shield may use and disclose Protected Health Information for

payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Cross Blue Shield's Notice of Privacy Practices is available on Highmark Blue Cross Blue Shield's Web site, or from the Highmark Blue Cross Blue Shield Privacy Department.

## PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

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 RRB. **DO NOT** pay Security Blue HMO or Freedom Blue PPO the Part D-IRMAA.



AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Number:		Agency Number:

**TO ENROLL IN SECURITY BLUE HMO OR FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (No P.O. Boxes)	Apt#	City	State	Zip
				County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip
				Date of Birth / /
Home Phone (with area code) ( )	Email Address (if applicable)			

**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.

<b>Medicare</b>	<b>Health Insurance</b>
SAMPLE ONLY	
Name _____	
Medicare Claim Number _____	Sex _____
_____	
Is Entitled To _____	Effective Date _____
<b>HOSPITAL (Part A)</b> _____	
<b>MEDICAL (Part B)</b> _____	

You must have Medicare Part A & Part B to join a Medicare Advantage Plan.

**PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:**

PLEASE MAKE ONLY ONE SELECTION

**Security Blue HMO**

- |   |   |
|---|---|
| <input type="checkbox"/> Value – \$68 per month   | <input type="checkbox"/> Standard – \$205 per month |
| <input type="checkbox"/> ValueRx – \$52 per month | <input type="checkbox"/> Deluxe – \$279 per month   |

**Freedom Blue PPO**

- |  |  |
|--|--|
| <input type="checkbox"/> ValueRx – \$123 per month | <input type="checkbox"/> Classic – \$319 per month |
| <input type="checkbox"/> Select – \$184 per month  |  |

**PAYING YOUR PLAN PREMIUM:**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) or on the web with eBill each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:**

Get a bill. Information about EFT and eBill will be included with your first bill.

- |   |                                    |  |                                   |
|---|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Monthly  | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Automatic deduction from your monthly Social Security or RRB benefit check. (The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.) |                                    |  |                                   |

**OTHER INSURANCE**

1. Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield health plan? ..... Yes  No   
If YES, name of plan: \_\_\_\_\_
2. Will either you or your spouse be employed once enrolled in Security Blue HMO or Freedom Blue PPO? ..... Self: ..... Yes  No   
Spouse: ..... Yes  No   
Your Retirement Date (Month/Day/Year): \_\_\_\_\_ Spouse's Retirement Date (Month/Day/Year): \_\_\_\_\_
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Security Blue HMO or Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes  No

**If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.**

**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 certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

**Annual Enrollment Period (October 15th through December 7th):**

If you are enrolling during the annual enrollment period from October 15th through December 7th of each year, and none of the options below apply, we will automatically process your enrollment as part of the Annual Enrollment Period – you do not need to fill out this page.

**NEW TO MEDICARE OR A CHANGE TO YOUR COVERAGE**

- I am new to Medicare.
- 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 employer or union coverage on \_\_\_\_\_ (insert date).
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

**RECENT 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 \_\_\_\_\_ (insert date).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on \_\_\_\_\_ (insert date).

**CHANGE IN INCOME OR SPECIAL NEEDS/PLAN QUALIFICATIONS**

- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on \_\_\_\_\_ (insert date).
- I belong to a pharmacy assistance program provided by my state.
- 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 was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on \_\_\_\_\_ (insert date).

If none of these statements applies to you or you're not sure, please contact Security Blue HMO or Freedom Blue PPO at 1-800-876-7639 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m.

**READ AND ANSWER THESE IMPORTANT QUESTIONS**

**Please choose the name of a Primary Care Provider (PCP), clinic or health center.**

Name of Provider (recommended)	PCP/NPI # (from the enclosed Provider Directory)
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The Security Blue HMO and Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? (Confirmed enrollment in Security Blue HMO or Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.) .....Yes  No

Do you have End-Stage Renal Disease? .....Yes  No

If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark Blue Cross Blue Shield member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. 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 to obtain additional information.

Are you enrolled in your State Medicaid program? .....Yes  No

If "YES," please provide your Medicaid Number: \_\_\_\_\_

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 and Phone Number of Institution (number and street): \_\_\_\_\_

**STOP! Please read this important information. If you currently have health care coverage from an employer or union, joining Security Blue HMO or Freedom Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Security Blue HMO or Freedom Blue PPO. Read the communications your employer or union sends you.**

**If you have questions, visit their Web site or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.**

**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 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 by Security Blue HMO, Freedom Blue PPO, or by Medicare.

Signature	Today's Date
-----------	--------------

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

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

**UPON RECEIPT OF YOUR APPLICATION, A COPY WILL BE RETURNED FOR YOUR RECORDS**

## ENROLLMENT APPLICATION



### INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

Please contact Security Blue HMO or Freedom Blue PPO at 1-866-682-7970 (TTY users should call 711) to inquire about materials on audio CD or for telephone translation services. Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

### WAYS TO ENROLL



**Mail:** Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Senior Markets  
Enrollment Department  
P.O. Box 535049  
Pittsburgh, PA 15253-9801



**Phone:** Complete your application over the phone toll-free at **1-866-682-7970** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.



**Online:** Complete your application online at **[www.highmarkbcbs.com/medicare](http://www.highmarkbcbs.com/medicare)**



**In person:** Bring your application to a Medicare Solutions Seminar or other authorized locations. Call the toll-free number to find a meeting in your area.

**West Central**

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

I understand that Security Blue HMO or Freedom Blue PPO will notify me in writing of my confirmed effective date of enrollment in Security Blue HMO or Freedom Blue PPO. I understand that, typically, my effective date will be the first of the month following the month in which Security Blue HMO or Freedom Blue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in Security Blue HMO or Freedom Blue PPO.

Keystone Health Plan West, Inc. is a HMO plan with a Medicare contract. Enrollment in Keystone Health Plan West, Inc. depends on contract renewal. Highmark Inc. is a PPO plan with a Medicare contract. Enrollment in Highmark Inc. depends on contract renewal.

Security Blue HMO and Freedom Blue PPO are Medicare Advantage Plans and have contracts with the Federal government. I will need to keep my Medicare Parts A and Part 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 is my responsibility to inform you of 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. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or 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 (RRB) benefit check each month.

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 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](http://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. 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 special circumstances.

Security Blue HMO and Freedom Blue PPO serve a specific service area. If I move out of the area that Security Blue HMO and Freedom Blue PPO serve, 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 Security Blue HMO or Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Security Blue HMO or Freedom Blue PPO 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 the Security Blue HMO and Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

I understand that beginning on the date Security Blue HMO coverage begins, I must get all of my health care from Security Blue HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Security Blue HMO and other services contained in my Security Blue HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR SECURITY BLUE HMO WILL PAY FOR THE SERVICES.**

I understand that beginning on the date Freedom Blue 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, Freedom Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in my Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM BLUE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Security Blue HMO or Freedom Blue PPO, he/she may be paid based on my enrollment in Security Blue HMO or Freedom Blue PPO.

### **RELEASE OF INFORMATION:**

By joining this Medicare health plan, I acknowledge that Security Blue HMO or Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Security Blue HMO or Freedom Blue PPO 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.

## PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Cross Blue Shield may use and disclose Protected Health Information for

payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Cross Blue Shield's Notice of Privacy Practices is available on Highmark Blue Cross Blue Shield's Web site, or from the Highmark Blue Cross Blue Shield Privacy Department.

## PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

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 RRB. DO NOT pay Security Blue HMO or Freedom Blue PPO the Part D-IRMAA.



AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Number:		Agency Number:

**TO ENROLL IN SECURITY BLUE HMO OR FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:**

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (No P.O. Boxes)	Apt#	City	State	Zip
				County
Mailing Address (P.O. Boxes allowed)	Apt#	City	State	Zip
				Date of Birth / /
Home Phone (with area code) ( )	Email Address (if applicable)			

**PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:**

**PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:**

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.

PLEASE MAKE ONLY ONE SELECTION

**Security Blue HMO**

- Value – \$64 per month
- ValueRx – \$42 per month
- Standard – \$201 per month
- Deluxe – \$237 per month

**Freedom Blue PPO**

- ValueRx – \$105 per month
- Select – \$137 per month
- Classic – \$280 per month

**PAYING YOUR PLAN PREMIUM:**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) or on the web with eBill each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option:**

Get a bill. Information about EFT and eBill will be included with your first bill.

- Monthly  Quarterly  Semi-Annually  Annually
- Automatic deduction from your monthly Social Security or RRB benefit check. (The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.)

<b>Medicare</b>	<b>Health Insurance</b>
SAMPLE ONLY	
Name _____	
Medicare Claim Number _____	Sex _____
Is Entitled To _____ Effective Date _____	
<b>HOSPITAL (Part A)</b> _____	
<b>MEDICAL (Part B)</b> _____	

You must have Medicare Part A & Part B to join a Medicare Advantage Plan.

**OTHER INSURANCE**

1. Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield health plan? ..... Yes  No   
If YES, name of plan: \_\_\_\_\_
2. Will either you or your spouse be employed once enrolled in Security Blue HMO or Freedom Blue PPO? ..... Self: ..... Yes  No   
Spouse: ..... Yes  No   
Your Retirement Date (Month/Day/Year): \_\_\_\_\_ Spouse's Retirement Date (Month/Day/Year): \_\_\_\_\_
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Security Blue HMO or Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes  No

**If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.**

**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 certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

**Annual Enrollment Period (October 15th through December 7th):**

If you are enrolling during the annual enrollment period from October 15th through December 7th of each year, and none of the options below apply, we will automatically process your enrollment as part of the Annual Enrollment Period – you do not need to fill out this page.

**NEW TO MEDICARE OR A CHANGE TO YOUR COVERAGE**

- I am new to Medicare.
- 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 employer or union coverage on \_\_\_\_\_ (insert date).
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

**RECENT 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 \_\_\_\_\_ (insert date).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on \_\_\_\_\_ (insert date).

**CHANGE IN INCOME OR SPECIAL NEEDS/PLAN QUALIFICATIONS**

- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on \_\_\_\_\_ (insert date).
- I belong to a pharmacy assistance program provided by my state.
- 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 was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on \_\_\_\_\_ (insert date).

If none of these statements applies to you or you're not sure, please contact Security Blue HMO or Freedom Blue PPO at 1-800-876-7639 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m.

**READ AND ANSWER THESE IMPORTANT QUESTIONS**

**Please choose the name of a Primary Care Provider (PCP), clinic or health center.**

Name of Provider (recommended)	PCP/NPI # (from the enclosed Provider Directory)
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The Security Blue HMO and Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Security Blue HMO or Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* .....Yes  No

Do you have End-Stage Renal Disease? .....Yes  No

If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark Blue Cross Blue Shield member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. 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 to obtain additional information.

Are you enrolled in your State Medicaid program? .....Yes  No

If "YES," please provide your Medicaid Number: \_\_\_\_\_

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 and Phone Number of Institution (number and street): \_\_\_\_\_

**STOP! Please read this important information. If you currently have health care coverage from an employer or union, joining Security Blue HMO or Freedom Blue PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Security Blue HMO or Freedom Blue PPO. Read the communications your employer or union sends you.**

**If you have questions, visit their Web site or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.**

**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 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 by Security Blue HMO, Freedom Blue PPO, or by Medicare.

Signature	Today's Date
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If you are the authorized representative, you must sign above and provide the following information:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

**UPON RECEIPT OF YOUR APPLICATION, A COPY WILL BE RETURNED FOR YOUR RECORDS**