HIGHMARK

MEDICARE ADVANTAGE

2024

Enrollment Application

Freedom Blue PPO

Delaware

Apply with this form, online or by phone. If you have any questions, we're here to help!

medicare.highmark.com

1-833-233-0401
(TTY 711)

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 8 p.m., Monday – Friday**

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

OMB No. 0938-1378
Expires: 7/31/2024

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 and December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Fill out this form online at medicare.highmark.com or mail your completed and signed form to:

Highmark Blue Cross Blue Shield

P.O. Box 535049

Pittsburgh, PA 15253-9801

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Highmark at 1-833-233-0401.
TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En espanol: Llame a Highmark al 1-833-233-0401 (los usuarios de TTY pueden llamar 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en espanol y un representate estara disponible para asistirle.

Individuals experiencing homelessness:

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Section 1 — All fields on this page are required unless marked optional

Please check which plan you want to enroll in:

- ☐ **Freedom Blue PPO Signature**
  $ 0 premium per month
- ☐ **Freedom Blue PPO Prestige**
  $ 39 premium per month
- ☐ **Freedom Blue PPO Valor**
  $ 0 premium per month
- ☐ **Freedom Blue PPO Distinct**
  $ 25 premium per month

First Name **Last Name** **Middle Initial (optional)**

Birth Date M M / D D / Y Y Y Y

Sex ☐ M ☐ F

Phone Number ( )

Permanent Residence Street Address (Don't enter a PO Box):

City **County** **State** **ZIP Code**

Mailing address, if different from your permanent address (PO Box allowed):

Street Address

City **State** **ZIP Code**

Your Medicare information

Medicare Number __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Highmark?

☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

Section 2 — All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ **I choose not to answer.**
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **I choose not to answer**

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

- ☐ I would like to receive my materials in a language other than English
- ☐ I would like to receive my materials in an accessible format (Braille, Large Print, etc.)

Please contact Highmark at 1-833-233-0401 if you need information in an accessible format or language other than English. TTY users should call 711. Our office hours are:

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Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

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

If yes, please provide Medicaid number: _____

List your primary care physician (PCP), clinic, or health center:

_____

Address of primary care physician (PCP), clinic, or health center:

_____

☐ I am a current patient of this provider.

Please provide your e-mail if you'd like communications related to health education, reminders, and other information (Optional).

E-mail: _____

These emails may include sensitive health information specific to your needs. If you opt in to receive emails, there is a chance that emails sent to you could be monitored, intercepted, read, and/or changed by an unauthorized third party before reaching your email inbox, and that it is possible that information intended for you could go to the wrong person or that your electronic accounts could be hacked. By opting in, you understand and accept these risks.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Section 1851 of the Social Security Act and 42 CFR §§422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of Eligibility for an Enrollment Period

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.

New to Medicare or a Change To Your Coverage

- ☐ I am making my annual enrollment period election (October 15 - December 7).
- ☐ I am new to Medicare.
- ☐ I recently involuntarily lost my creditable prescription coverage ("creditable" means coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).
- ☐ I am leaving or have left 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 or plan to move outside of the service area for my current plan, or I recently moved or plan to move and this plan is a new option for me _____ (insert move date).
- ☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home).
- ☐ I moved/ will move into/ out of the facility on _____ (insert date).
- ☐ I recently obtained lawful presence status in the U.S. I got this status on _____ (insert date).
- ☐ I recently was released from incarceration. I was released 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) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on _____ (insert date).

- [ ] I belong to a pharmacy assistance program provided by my state.
- [ ] I recently left a PACE plan (Program of All-Inclusive Care for the Elderly) 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).
- [ ] I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- [ ] I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on _____ (insert date).
- [ ] I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, lost Medicaid) on _____ (insert date).

Other Reason

- [ ] I am in a plan that is identified as a consistent poor performer.
- [ ] I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- [ ] I am enrolling in a 5-Star Medicare plan.
- [ ] None of the above apply.

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) each month, quarterly, biannually, or annually. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

Please select your premium payment option:

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

I would like to receive a bill:

- [ ] Monthly
- [ ] Quarterly
- [ ] Semi-Annually
- [ ] Annually

- [ ] Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from:
  - [ ] Social Security
  - [ ] RRB

(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.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Highmark the Part D-IRMAA.

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this Highmark Medicare Advantage plan.
- By joining this Medicare Advantage Plan, I acknowledge that Highmark will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement above).
- I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this Highmark plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 when my Highmark coverage begins, I must get all of my medical and prescription drug benefits from Highmark. Benefits and services provided by Highmark and contained in my Highmark "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Highmark will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 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

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 _____

Broker/Agent Name :_____ ID # _____

Agency_____

Notice of Nondiscrimination

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.