

Group Medicare Advantage Enrollment Request Form



Who can use this form?

People with Medicare who want to join a Group 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 Group Medicare Advantage Plan, you must be determined eligible to enroll by your group administrator and also have both:

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

When do I use this form?

Please refer to your enrollment materials for information on when you can enroll in this Group Medicare Advantage Plan.

Note: If you and your spouse or Medicare-eligible dependent are applying, each of you will need to fill out a separate enrollment request form.

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

What happens next?

Send your completed and signed form to:

Questions?

For eligibility and enrollment questions, call:

For benefit plan questions, call:

CareFirst BlueCross BlueShield Medicare Advantage

Monday through Friday 8:00 am to 6:00 pm ET

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 IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

☐ CareFirst BlueCross BlueShield Group Medicare Advantage (PPO)**CONTACT INFORMATION**

Employer or Union Group Name:

First Name:

Last Name:

Middle Initial (optional):

Birth Date:

Sex:

☐ Male ☐ Female

Home Phone Number:

Mobile Phone (optional):

Permanent Residence Street Address (For individuals experiencing homelessness, a PO Box may be considered your permanent address.):

County:

City:

State:

ZIP Code:

Mailing Address, if different from your Permanent Address (PO Box allowed):

City:

State:

ZIP Code:

Email Address: (optional)

MEDICARE INFORMATION

Medicare Number:

Part A Effective Date:

Part B Effective Date:

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareFirst BlueCross BlueShield Medicare Advantage? Yes No

Name of other coverage:

Member number for this coverage:

SECTION 1—ALL FIELDS IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)

Group number for this coverage:

SECTION 2—ALL FIELDS IN THIS SECTION 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, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer**

What's your race? Select all that apply.

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

What is your gender? Select one.

- Woman I use a different term: _____
 Man **I choose not to answer**
 Non-binary

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay I use a different term: _____
 Straight, that is, not gay or lesbian I don't know
 Bisexual **I choose not to answer**

Select if you want us to send you information in a language other than English.

- ☐ Spanish

Select one if you want us to send you information in an accessible format.

- ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact the number listed in your enrollment materials if you need information in an accessible format or language other than what is listed above.

SECTION 3—IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareFirst BlueCross BlueShield Group Medicare Advantage.
- I understand that I can be enrolled in only one Medicare Advantage plan at a time—and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA).
- By joining this Group Medicare Advantage Plan, I acknowledge that CareFirst BlueCross BlueShield Group Medicare Advantage 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 below).
- 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 CareFirst BlueCross BlueShield Group Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareFirst BlueCross BlueShield Group Medicare Advantage. Benefits and services provided by CareFirst BlueCross BlueShield Group Medicare Advantage and contained in my CareFirst BlueCross BlueShield Group Medicare Advantage “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareFirst BlueCross BlueShield Group Medicare Advantage 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're the authorized representative, sign above and fill out these fields

Name:

Address:

Phone Number:

Relationship to Enrollee:

EMPLOYER GROUP USE ONLY	
Employer or Union Group Name:	
Subgroup Name/Number (if applicable):	Employer Group Number:
Employer Receipt Date:	Authorized Representative Name:

SECTION 4—FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.	
Name:	Relationship to enrollee:
Signature	National Producer Number (Agents/Brokers only):

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. Sections 1851 and 1860D-1 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.

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Notice of Nondiscrimination and Multi-Language Insert

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid 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, please call 1-833-320-2664.

If you believe CareFirst 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 our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	civilrightscordinator@carefirst.com
Telephone Number	410-528-7820
Fax Number	410-505-2011

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
800-368-1019, 800-537-7697 (TDD)

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

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CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-320-2664. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-320-2664. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-833-320-2664。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-320-2664。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-320-2664. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-320-2664. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-320-2664 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-320-2664. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-320-2664 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-320-2664. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-320-2664. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-320-2664 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-320-2664. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-320-2664. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-320-2664. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-320-2664. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますごさい。通訳をご用命になるには、1-833-320-2664 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。