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

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug 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 Prescription Drug Plan, you must also have either, or 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-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.

Reminders:

- ☐ 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?

Send your completed and signed form to:
Blue Cross and Blue Shield of Kansas
P.O. Box 659403
San Antonio, TX 78265-9714
Or **fax** to: 1-800-833-8554

You can also enroll **online** at: https://shop.partdkansas.com/medicare

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

How do I get help with this form?

Call Blue Cross and Blue Shield of Kansas at **1-877-471-4121**. 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 español: Llame a Blue Cross and Blue Shield of Kansas al **1-877-471-4121/ 711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará 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.

BlueCross BlueShield Kansas

An independent licensee of the Blue Cross Blue Shield Association.

Blue Cross and Blue Shield of Kansas

Medicare Prescription Drug Plan

Individual Enrollment Form-2023

Section 1-All fields below are required (unless marked optional). Please check the plan you want to enroll in.	
☐ **013 Blue MedicareRx Value (PDP)** **$58.20 per month**	☐ **014 Blue MedicareRx Plus (PDP)** **$48.60 per month**

Last name	**First name**	**MI**

Birthdate (MM/DD/YYYY)	Sex ☐M ☐F	Email (Optional) @ _____

Phone number Is this a mobile number? ☐Yes ☐No	**Alternate phone number** Is this a mobile number? ☐Yes ☐No

Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email, phone call or text with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by ☐email and/or ☐text? Messaging and data rates may apply.

Please know you can change your preference at any time by visiting **www.bcbsdirect.com/ks/login** or contacting customer service.

Permanent residence street address (Don't enter a P.O. Box)

City	State	ZIP code	County

Mailing address (only if different from your permanent address; P.O. Box allowed)

City	State	ZIP code

Your Medicare information

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Please locate the 11-digit alpha-numeric number on your Medicare Card. **Example:** 1EG4-TE5-MK72

Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

enrollment form

Applicant Complete: Name _____ and Medicare Number _____

Answer these important questions:				
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Cross and Blue Shield of Kansas? ☐ Yes ☐ No				
Name of other coverage:	Member number for this coverage:	Group number for this coverage:	Start Date: (MM/DD/YYYY)	End Date: (MM/DD/YYYY)

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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer**

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
- ☐ Samoan
- ☐ **I choose not to answer**

Please check one of the boxes below if you would prefer us to send you information in an accessible format:

☐ Voice-Enabled (Audio) PDF ☐ Large Print

Please contact Blue Cross and Blue Shield of Kansas at **1-877-471-4121** if you need information in an accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call **711.**

Are you interested in having prescriptions mailed to you through our Home Delivery program? ☐ Yes

Applicant Complete: Name _____

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or electronic funds transfer (EFT) each month. **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.**

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. DON'T pay Blue Cross and Blue Shield of Kansas the Part D-IRMAA.

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

Please select a premium payment option:

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your **first** payment.) **Please complete information below:**

Account Type ☐ **Checking** - May enclose a VOIDED check or provide the following information: ☐ **Savings - MUST** enclose a letter from financial institution with account and routing information.

Account holder name _____ Bank name _____

Bank routing number* | | | | | | | | | |

(*This is the first 9 digits printed on the lower left corner of your check.)

Bank account number | | | | | | | | | | | | | | | | |

I authorize the bank above to deduct my monthly premiums.

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

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

Applicant Complete: Name _____

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Prescription Drug Plan (PDP) only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year. Additionally, there are exceptions - i.e., Initial Enrollment Period (IEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Please read the following statements carefully and check all of the boxes where there is a statement that 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.

NOTE: At least one option below needs to be selected.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (IEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ I recently moved outside my service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____. (SEP)
- ☐ 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. (SEP)
- ☐ 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) _____. (SEP)
- ☐ 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. (SEP)
- ☐ I recently had a change in my Medicaid/Extra Help paying for my Medicare prescription drug coverage (newly got Medicaid/Extra Help, had a change in the level of Medicaid/Extra Help, or lost Medicaid/Extra Help) on (insert date) _____. (SEP)
- ☐ 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) _____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____. (SEP)
- ☐ I am leaving employer or union coverage. Employer/Union coverage started on (insert date) _____ and coverage ends on (insert date) _____. (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____. (SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
- ☐ I was recently released from incarceration. I was released on (insert date) _____. (SEP)
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____. (SEP)
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)

Applicant Complete: Name _____

☐ Other*_____

*If none of these statements apply to you or you're not sure, please contact Blue Cross and Blue Shield of Kansas at **1-877-471-4121** (TTY users should call **711**) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Section 3 - IMPORTANT: Please read and sign below
☐ I must keep Hospital (Part A) or Medical (Part B) to stay in Blue MedicareRx Value (PDP) or Blue MedicareRx Plus (PDP).
☐ By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross and Blue Shield of Kansas 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.
☐ I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D 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 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 Required to process your application.

Applicant signature **X**	**Today's date**
Desired plan effective date*:	

*Subject to Medicare election period guidelines

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name First Name	Last Name	
Address		
City	**State**	**ZIP code**
Phone Number	**Relationship to Enrollee**	
☐ **I have submitted Authorized Representative documentation with this application.**		

enrollment form

Applicant Complete: Name _____

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.

☐ IEP ☐ AEP ☐ OEP ☐ SEP (type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Scope of Appointment (SOA)

Appointment type: ☐ Face-to-face ☐ Telephone ☐ Webcam

How was the scope of appointment (SOA) collected?

☐ Paper ☐ Electronic ☐ Recorded call (voice recording ID) _____

Print name _____ _____
First Name Last Name

Writing Agent encrypted TIN (10 digits) __ __ __ __ __ __ __ __ __ __

Agency encrypted TIN (10 digits) __ __ __ __ __ __ __ __ __ __

Agency Name _____

Phone _____

Email @ _____

Signature _____ Application received date _____

BCBSKS is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Part D plans noted. BCBSKS serves all counties in Kansas, except Johnson and Wyandotte. BCBSKS is an independent licensee of the Blue Cross Blue Shield Association (Association). ®The Blue Cross Blue Shield names and symbols are registered marks of the Association.

Translation services are available; please contact the plan or your agent.

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.

Applicant Complete: Name _____