MEDICARE ADVANTAGE GROUP ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another language or format (Braille), please call 1-855-215-9239 (TTY 711).

Monday – Friday, 8 a.m. to 4:30 p.m.

Mailing Address: P.O. Box 15013, Albany, NY 12212 • Physical Address: 40 Century Hill Drive • Latham, NY 12110

PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Employer or Union Name CASHIC - Schalmont CSD Medicare **Location** _____

Member plan selection:

☑	Forever Blue 799 (PPO) Plan CF12	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____
☐	_____	☐	_____

Effective Date _____ **Member bill level selection:** ☑ **Group bill** ☐ **Member bill**

PART 2 PLEASE TELL US ABOUT YOURSELF

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Email Address _____

PERMANENT RESIDENCE STREET ADDRESS: **(Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)**

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____
area code area code

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 3 MEDICAL ELIGIBILITY INFORMATION

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Entitled to:

Hospital (Part A) Effective Date _____ / _____ / _____

Medical (Part B) Effective Date _____ / _____ / _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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PART 4 **PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY**

Doctor's Last Name _____ First Name _____

Current Patient? ☐ Yes ☐ No

PART 5 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. **Are you the retiree?** ☐ Yes ☐ No

   If YES, retirement date (MM/DD/YYYY)_____

   If NO, name of retiree_____

2. **Are you the spouse of the retiree?** ☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer or union plan?** ☐ Yes ☐ No

   If YES, name of spouse_____

   Name of dependents _____

4. **Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Highmark Blue Shield HMO or PPO?** ☐ Yes ☐ No

   If YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage_____

   ID# for this coverage_____Group# for this coverage_____

5. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No

   If YES, please list the institution's name, address, phone number, and date of admission.

   Name_____Street_____ Suite#_____

   City_____State_____ ZIP Code_____

   Phone ( )_____ County _____ Date of Admission _____
   area code (MM/DD/YYYY)

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number _____

7. **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?** ☐ Yes ☐ No

   If YES, what kind of insurance do you have? _____

   What is the name of your insurance? _____

8. **Do you or does your spouse work?** ☐ Yes ☐ No

PART 6 **PLEASE READ AND SIGN ON PAGE 4**

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

Highmark Blue Shield HMO or PPO are Medicare Advantage Plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and 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. 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. 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 if an enrollment period is available (example: annual enrollment period from October 15 – December 7), or under certain special circumstances.

Highmark Blue Shield HMO or PPO serve a specific service area. If I move out of the area that Highmark Blue Shield HMO or PPO serves, 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 Highmark Blue Shield HMO or PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Highmark Blue Shield HMO or PPO once I receive 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, beginning on the date Highmark Blue Shield HMO or PPO coverage begins, I must get all of my health care from Highmark Blue Shield, except for emergency or urgently needed services or out-of-area dialysis services. I understand that, beginning on the date Highmark Blue Shield HMO or 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, Highmark Blue Shield HMO or PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by Highmark Blue Shield and other services contained in my Highmark Blue Shield HMO and PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HIGHMARK BLUE SHIELD 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 Highmark Blue Shield, the employee may be paid based on my enrollment in Highmark Blue Shield HMO or PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Shield will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

PART 6 **ENROLLEE AUTHORIZATION — SIGNATURE**

Enrollee Authorization

_____ _____

Signature **Today's Date**

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

Last Name _____ First Name _____ Middle Initial _____

Street/Apartment# _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Relationship to Enrollee _____
area code

Please include a copy of your Power of Attorney paperwork.

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
- ❑ Somoan
- ❑ **I choose not to answer**

What is your gender? Select One.

- ❑ Woman ❑ Man ❑ Non-binary ❑ I use a different term_____
- ❑ **I choose not to answer**

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

- ❑ Lesbian or gay ❑ Straight, that is not gay or lesbian ❑ Bisexual
- ❑ I use a different term_____ ❑ I don't know ❑ **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, Data CD, Audio CD, etc.)

Please contact Highmark at 1-800-329-2792 if you need information in an accessible format or language other than English. TTY users should call 711. Our office hours are:

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 5 p.m., Monday – Friday**

For individuals helping enrollee with completing this form only

Name: _____

National Producer Number (Agents/Brokers only): _____

Relationship to Enrollee: _____

Effective Date of Coverage:_____

Date Received:_____

Signature: _____

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- 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 Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, 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.

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY: 711)

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

我們免費提供口譯服務，爲您解答有關我們健康計畫或藥物計畫的任何疑問。若要獲得口譯服務，只需撥打您所在州的電話號碼即可。講漢語的工作人員可爲您提供協助。此項服務免費。

Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na posibleng mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang ang numerong ibinigay para sa estadong tinitirhan mo. May taong nagsasalita ng Tagalog na makakatulong sa iyo. Isa itong libreng serbisyo.

Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime d'assurance maladie ou d'assurance médicaments. Pour obtenir les services d'un interprète, il vous suffit d'appeler le numéro correspondant à votre État de résidence. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc của quý vị về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi số được cung cấp cho tiểu bang cư trú của quý vị. Ai đó nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

Wir verfügen über kostenlose Dolmetschdienste, damit Sie alle eventuellen Fragen zu unserer Krankenversicherung oder zur Medikamenten-Zusatzversicherung klären können. Rufen Sie hierzu einfach die Nummer für den Bundesstaat an, in dem Sie Ihren Wohnsitz haben. Jemand, der Deutsch spricht, wird Ihnen behilflich sein. Dies ist ein kostenloser Service.

لدينا خدمات ترجمة فورية مجانية للإجابة عن أي أسئلة قد تراودك حول خطتنا الصحية أو الدوائية. للحصول على مترجم فوري، فقط اتصل بالرقم المقدم للولاية التي تقيم فيها. ويمكن لشخص يتحدث العربية مساعدتك. هذه خدمة مجانية.

건강 또는 약물 플랜에 대한 귀하의 질문에 답변해 드릴 수 있는 무료 통역 서비스를 제공해 드립니다. 통역사를 구하려면 거주하시는 주의 전화 번호로 문의하십시오. 한국어을(를) 말할 수 있는 직원이 도와드릴 수 있습니다. 이 서비스는 무료로 제공합니다.

Мы предоставляем бесплатные услуги устного перевода, чтобы помочь вам получить ответы на любые вопросы, которые могут у вас возникнуть в отношении нашего медицинского плана или плана лекарственных препаратов. Чтобы заказать услуги переводчика, просто позвоните по номеру, указанному для штата, в котором вы проживаете. Один из наших переводчиков, специализацией которого является русский язык, поможет вам. Эта услуга предоставляется бесплатно.

हमारे पास हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ्त दुभाषिया सेवाएँ हैं। एक दुभाषिया प्राप्त करने के लिए, बस अपने निवास स्थान की स्टेट के लिए दिए गए नंबर पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह एक निःशुल्क सेवा है।

Disponiamo di servizi di interpretariato gratuiti per rispondere a ogni sua domanda riguardo al suo piano sanitario o farmaceutico. Per ottenere l'assistenza di un interprete, chiami il numero fornito per il suo stato di residenza. Qualcuno che parla italiano la aiuterà. Il servizio è gratuito.

Temos serviços de interpretação gratuitos para esclarecer suas dúvidas sobre nosso plano de saúde ou de medicamentos. Para contar com um intérprete, ligue para o número fornecido para o seu estado de residência. Alguém que fale Português pode ajudar você. Este é um serviço gratuito.

Nou gen sèvis entèpretasyon gratis pou reponn ak nenpòt kesyon ou ta ka genyen sou plan asirans sante oswa medikaman nou an. Pou jwenn yon entèprèt ede w, senpleman rele nimewo ki koresponn ak Eta kote w rete a. Yon moun ki pale Kreyòl Ayisyenap ede w. Sèvis sa a gratis.

Dysponujemy darmowymi usługami tłumaczeniowymi, dzięki którym może Pan/Pani uzyskać odpowiedzi na pytania dotyczące naszego planu zdrowia lub leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka. Ktoś, kto zna język polsku, może Panu/Pani pomóc. Ta usługa jest darmowa.

当院では、無料の通訳サービスを用意し、治療や投薬計画に関するご質問にお答えしています。通訳を手配したい場合は、お住まいの州で指定された番号までお電話でご連絡ください。日本語話せる者が対応をお手伝いします。サービスは無料でご利用いただけます。