Blue Cross Blue Shield of Rhode Island

Plan 65® Individual Enrollment Request Form

Please be sure to complete all information below to avoid delays in processing.

Section 1 – Please check the plan in which you would like to enroll					
Plan 65 Coverage					
☐ Plan A	☐ Plan F	☐ Select F	☐ Plan G	☐ Select G	☐ Plan N
Dental Direct Coverage					
☐ Dental Direct Basic	☐ Dental Direct Standard	☐ Dental Direct Plus	☐ Dental Direct Elite		

Section 2 – Please provide personal information (please print)			
Last Name	**First Name**	**Middle Initial**	
Date of Birth / /	**Sex** ☐ M ☐ F	**Home Phone Number** ( )	**Cell Phone Number** ( )
Social Security Number* - -	**Current BCBSRI ID** (if applicable)	**Primary Language**	
Permanent Residence Street Address (P.O. Box is not allowed)			
City	**State**	**Zip Code**	
Mailing Address (only if different from Permanent Residence Street Address)			
City	**State**	**Zip Code**	
Email Address			

Section 3 – Tobacco use	
Have you smoked cigarettes or used any tobacco product at any time in the past twelve months?	☐ Yes ☐ No

Section 4 – Please provide your current or prior insurance information	
What is the name of your current or prior health insurance carrier?	
When will your coverage terminate? / /	Please attach a copy of your Certificate of Creditable Coverage showing the coverage end data, unless you are enrolled with BCBSRI or are new to Medicare Part B. **Application will not be processed until received.**
What is the name of your current or prior dental insurance carrier?	

*Social Security number is required to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans

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Section 5 – Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section.
Fill out this information exactly as it appears on your Medicare card.

Name	
Medicare number	

Is entitled to: Effective Date:

Hospital (Part A) ______________________________

Medical (Part B) ______________________________

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

Section 6 – Eligibility for an enrollment period

You do not need more than one Medicare Supplement policy. If you purchase the policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

The benefits and subscriber feeds under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, please notify us to have your Medicare Supplement policy reinstituted. You must notify us within 90 days of losing Medicaid eligibility.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and medical assistance through the state Medicaid program including benefits as a Qualified Medicare Beneficiary (QMB) and Specified Low-income Medicare Beneficiary (SLMB).

To the best of your knowledge:

Question	Yes	No
1. Do you have another Medicare Supplement policy or certificate in force?	☐ Yes	☐ No
If yes, with which insurer?		
If yes, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes	☐ No
2. Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?	☐ Yes	☐ No
If yes, with which insurer?		
What kind of policy?		
3. Do you have a Medicare Advantage policy?	☐ Yes	☐ No
If yes, with which insurer?		
4. Are you covered by medical assistance through the state Medicaid program?	☐ Yes	☐ No
a. As a Specified Low-income Medicare Beneficiary (SLMB)?	☐ Yes	☐ No

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Section 6 – Eligibility for an enrollment period

b. As a Qualified Medicare Beneficiary (QMB)?			☐ Yes ☐ No
c. For other Medicaid medical benefits?			☐ Yes ☐ No
5. Are you transferring from an out-of-state Medicare Supplement plan?			☐ Yes ☐ No
If yes, please include the following:			
Name:	State:	Type:	
6. Have you received the Notice of Replacement Coverage?			☐ Yes ☐ No
7. Are you eligible for group healthcare through an insurance carrier?			☐ Yes ☐ No
If yes, please provide the name of the group or company:			

Section 7 – Plan 65 Plan Select F and Plan Select G disclosure statement

If applying for Plan Select F or Plan Select G, by signing this application I certify I have received the following information as applicable and understand the restrictions of the Plan Select F or Plan Select G benefit plan I have chosen.

- A listing of the Plan Select F or Plan Select G hospital network
- An outline of coverage comparing the Plan Select F or Plan Select G benefit plan I have chosen with all Plan 65 benefit plans offered by Blue Cross & Blue Shield of Rhode Island (BCBSRI)
- A description of applicable benefits, coinsurance, and deductibles when you use a hospital within the Plan 65 Select Hospital Network
- A description of coverage for emergency and urgently needed care and other out-of-service area coverage
- A description of limitations on referrals to Plan Select F or Plan Select G non-participating hospitals
- A description of my right to purchase any other Medicare Supplement contract offered by BCBSRI
- A description of the Medicare Select issuer's quality assurance program and grievance procedure
- I understand that if I use a non-participating Plan 65 Select Hospital for Medicare Part A benefits, I will be responsible to pay the applicable Medicare eligible expenses, Part A deductible, and/or Part A copayment; and
- I understand that the Plan 65 Select Hospital Network is subject to change at any time. I will be notified of any changes in the network as well as my rights regarding a plan change.

Section 8 – Dental Direct disclosure statement

DENTAL DIRECT IS NOT A MEDICARE SUPPLEMENT INSURANCE PLAN.

- A 12-month waiting period applies to root canals, periodontal services, oral surgery, crowns, and prosthodontics on some plans.
- We will accept evidence of substantially similar prior coverage to meet the waiting period requirement. You must provide the applicable information within 60 days of the requested effective date of the dental plan.
- If you terminate coverage and then re-apply, the waiting period listed above will apply without accounting for your prior coverage.

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Section 9 – Paying your plan premium

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

☐ Option 1 – Electronic Funds Transfer (EFT) from your back account each month.

1. Fill out the information below:

   Account Holder Name: ______________________________

   Bank Routing Number: ______________________________

   Bank Account Number: ______________________________

   Account Type: ☐ Checking ☐ Savings

2. Attach a voided check to this form. Write "VOID" on the blank check from the account from which you want payments withdrawn. Do NOT send a deposit slip, blank check, or cancelled check.

☐ Option 2 – Direct bill
Please select a premium payment option: ☐ Receive a bill monthly ☐ Receive a bill quarterly

Section 10 – Please read and sign below

By completing this enrollment application, I certify and agree that:

1. I have read the above statements, or that they have been read to me, and all responses on this application are true to the best of my knowledge. If anyone knowingly lies or hides the truth, BCBSRI has the right to:
   - Reduce or deny a claim
   - Cancel the plan back to the effective date
   - Recoup any monies paid back to the effective date
2. The enrollee is the person responsible for the payment of premiums.
3. No covered benefits will apply until the plan is made effective by BCBSRI.

Signature: ______________________________ **Today's Date:** ____________________

If you are the enrollee, please ensure you have signed above. If you are signing on behalf of the enrollee, please sign above AND complete the authorized representative section below.

Authorized representative personal information (please print)

First Name		Last Name
Address		
City	State	Zip Code
Relationship to Enrollee		Phone Number: ( )

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Section 11 – Contact information
Please mail this form to: Blue Cross & Blue Shield of Rhode Island Attn: Medicare Sales Department 500 Exchange Street Providence, RI 02903-2699 **For questions:** Call the Medicare Sales department (401) 351-BLUE (2583) or 1-800-505-BLUE (2583) (outside of Rhode Island)

Internal use only – To be completed by Agent			
Application Code	☐ New ☐ TConv ☐ NConv ☐ NConv2 ☐ AEP ☐ Other ___________		
Rate	☐ Age-in ☐ Base	Tobacco Status	☐ Tobacco ☐ Non-Tobacco
Sales Agent Signature (if assisted in enrollment)		Agent Received Date	
Print Sales Agent Name		Broker ID#	
Effective Date of Coverage:			

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