



INSTRUCTIONS: Please complete all sections of this form. Please read each statement in Section I. Sign and date where indicated in Section G. Mail completed form to: Enrollment Services, P.O. Box 8438, Philadelphia, PA 19101-8438. For information, call 1-866-434-2038, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-866-456-1550).

A. Personal Information (Please print clearly):

Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (MM/DD/YYYY) __/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (optional):	Home Phone Number: ()
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Permanent Residence Street Address:

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address)

Street: City: State: ZIP Code:

B. Enroll me in the plan checked below (these are monthly premiums):

<input type="checkbox"/> MedicareBlue PPO Essential Plus Rx1 - \$51.00	<input type="checkbox"/> MedicareBlue PPO Enhanced Plus Rx2 - \$144.00
<input type="checkbox"/> MedicareBlue PPO Enhanced Plus Rx1 - \$90.00	<input type="checkbox"/> MedicareBlue PPO Enhanced Plus Rx3 - \$201.00

C. Please Provide Your Medicare Insurance Information


Please take out your Medicare Card to complete this section.

- Fill in the blanks so they match your red, white and blue Medicare card exactly.

- OR -

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

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

MEDICARE  HEALTH INSURANCE	
Name: _____	Sex: _____
Medicare Claim Number: _____	
_____ - _____ - _____	
Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Medicare Prescription Drug Plan Use Only

Office Use Only

Name of staff member (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: ___ OEP: ___ AEP: ___ SEP (type): ___ Not Eligible: ___

D. Enrollment Period Determination

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. Please read the following statements and check one box to the left of the statement and we will contact you for additional information.

- I am enrolling during the annual enrollment period, November 15 through December 31
- I am enrolling during the Medicare Advantage open enrollment period, January 1 through March 31
- I am new to Medicare. My effective date is (mm/dd/yyyy) ___ / ___ / _____
- I moved outside of the service area for my current plan on (mm/dd/yyyy) ___ / ___ / _____
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums
- I receive extra help paying for Medicare prescription drug coverage as of (mm/dd/yyyy) ___ / ___ / _____
- I live in a Long Term Care Facility (for example, a nursing home or long-term care facility) as of (mm/dd/yyyy) ___ / ___ / _____
- I moved "out" of a Long Term Care Facility (for example, a nursing home or long-term care facility) as of (mm/dd/yyyy) ___ / ___ / _____
- I left a PACE program on (mm/dd/yyyy) ___ / ___ / _____
- I involuntarily lost my creditable prescription drug coverage (as good as Medicare's) on (mm/dd/yyyy) ___ / ___ / _____
- I am either losing coverage I had from an employer or union or leaving employer or union coverage as of (mm/dd/yyyy) ___ / ___ / _____
- I belong to a pharmacy assistance program provided by my state
- After living permanently outside the United States, I recently returned to the U.S. on (mm/dd/yyyy) ___ / ___ / _____
- I am no longer eligible for extra help paying for my Medicare prescription drugs as of (mm/dd/yyyy) ___ / ___ / _____
- I am enrolled in the Original Medicare Plan
- Other Medicare Advantage coordinated special enrollment periods as of (mm/dd/yyyy) ___ / ___ / _____

If none of the statements apply to you or if you are not sure, please call Customer Service at 1-866-434-2038 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-866-456-1550) to see if you are eligible to enroll.

E. Paying Your Plan Premium (also see Section I):

You can pay your monthly plan premium by mail or by Electronic Funds Transfer (EFT) each month. After your coverage takes effect, you can also choose to pay your premium by automatic deduction from your Social Security check each month. If you are interested in other payment options, please contact us at 1-888-457-3009, 8 a.m. to 8 p.m. daily, Central and Mountain Time (TTY/TDD: 1-888-457-3005). If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. Generally, you must stay with the option you choose for the rest of this year. If you don't select a payment option, you will receive a bill each month. **Please select a premium payment option (do not send a payment with this application):**

- Receive a paper bill each month
- Electronic Funds Transfer (complete EFT form)*

* If you selected EFT as your premium payment option, please be sure to complete the EFT form included in the enrollment kit and mail it with your enrollment form. Please note that it may take up to **two months** to process your request. Please pay your premiums billed to you on paper until your EFT is active.

F. Please Read and Answer These Important Questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No
If you answered "yes" to this question and you do not need regular dialysis, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant. (Also see Section I.)
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to MedicareBlue PPO? Yes No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
Name of coverage: _____ ID number for this coverage: _____ Group number for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If yes, please provide the following information:
Name of institution: _____ Phone number of institution: _____
Address of institution (number and street): _____
4. Are you enrolled in your State Medicaid program? Yes No
If yes, please provide your Medicaid Number: _____
5. Do you or your spouse work? Yes No

G. Please Read Sections H and I and Sign Below:

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application including the information in Sections H and I. 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 by MedicareBlue PPO or by Medicare. 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.

Your Signature: _____ Today's Date: _____

If you are the authorized representative, you MUST provide the following information:

Name (Print): _____ Phone Number: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Relationship to Enrollee: _____

Check if Applicant received assistance in completing this form. The person who assisted Applicant must sign below.

Assistant Signature: _____ Date: _____ Relationship to Applicant: _____

Agent Name (Print): _____ Agent #: _____ Agency #: _____

Agent Signature: _____ Date: _____ Phone Number: _____

H. STOP - Please Read This Important Information - STOP

If you currently have health coverage from an employer or union, joining *MedicareBlue PPO* could affect your employer or union health benefits and may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

I. Enrollment Authorization - Please read carefully. Sign Section G after reading all statements in this section. Keep the copy marked "Applicant" for your records.

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

1. I understand MedicareBlue PPO is a regional Medicare Advantage plan with a Medicare contract. MedicareBlue PPO coverage is provided by only one of the following plans, depending on the state in which the policy is issued: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*
2. I understand that MedicareBlue PPO is a Medicare Advantage plan and I will need to keep my **Medicare Part A and Part B insurance** by paying the Part A and Part B premiums, if applicable. I also understand that I can be a member of only **one Medicare Advantage plan at a time**. By enrolling in MedicareBlue PPO, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member.
3. It is my responsibility to inform MedicareBlue PPO of any prescription drug coverage that I have or may get in the future.
4. I understand that enrollment in MedicareBlue PPO is generally for the entire year. I understand I may leave MedicareBlue PPO only at certain times of the year, or under certain special circumstances, by sending a written request to MedicareBlue PPO or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, seven days a week. Until the effective date of disenrollment, plan benefits continue to apply to obtained services and I must keep getting health care from plan doctors in order to receive the maximum benefit.
5. I understand that MedicareBlue PPO serves a specific service area. If I move out of the area that MedicareBlue PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
6. I understand that once I am a member of MedicareBlue PPO, I have the right to **appeal MedicareBlue PPO's decisions** about payment or services if I disagree. I will read the Evidence of Coverage from MedicareBlue PPO when I receive it to know the rules I must follow in order to receive coverage with this Medicare Advantage plan.
7. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
8. I understand that beginning on the date MedicareBlue PPO coverage begins, I must get all of my health care from MedicareBlue PPO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by MedicareBlue PPO and other services contained in my MedicareBlue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICAREBLUE PPO WILL PAY FOR THE SERVICES**.
9. For MedicareBlue PPO Enhanced Plus Rx3 applicants only: I understand that by joining this plan, I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.
10. I understand that by joining this Medicare Advantage health plan, I acknowledge that MedicareBlue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MedicareBlue PPO will release my information, including my prescription drug event data, to Medicare who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
11. I understand that MedicareBlue PPO will send me final approval of my enrollment. I understand that I should not disenroll from **any Medicare supplement plan, Medigap or Medicare Select plan** until I get that approval from MedicareBlue PPO.
12. If I have **ESRD** (end stage renal disease), I cannot enroll in MedicareBlue PPO unless I am already enrolled in this organization as a commercial member or I was affected by the non-renewal of another Medicare Advantage plan after December 31, 1998.
13. I understand that the person discussing plan options with me is either employed by or contracted with one of the independent Blue Cross and Blue Shield Plans offering MedicareBlue PPO, listed above. The person may be compensated based on my enrollment in a plan.

*Independent licensees of the Blue Cross and Blue Shield Association

Distribution: White Copy: Carrier Yellow Copy: Applicant



2008 Individual Enrollment Form

Follow these easy steps to enroll:

1. Review the Summary of Benefits included in "Your 2008 MedicareBlue PPO Easy Enrollment Kit."
2. Contact an authorized independent agent or call one of our MedicareBlue PPO representatives to help you determine which plan is right for you.
3. Enroll by:
 - Filling out the enrollment form and returning it in the postage-paid return envelope
 - Enrolling online at www.YourMedicareSolutions.com
 - Calling MedicareBlue PPO Customer Service at 1-866-434-2038 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-866-456-1550) and we'll enroll you right over the phone.

For More Information ...

Contact your authorized independent agent

Or call MedicareBlue PPO toll-free: 1-866-434-2038

TTY/TDD users should call: 1-866-456-1550

8 a.m. to 8 p.m., daily, Central and Mountain Time

Or visit us on the Web at www.YourMedicareSolutions.com