



MedicareBlueSM PPO (Regional PPO)

A Medicare Advantage Plan

2010

Individual Enrollment Form

Follow these easy steps to enroll:

1. Review the Summary of Benefits included in your 2010 MedicareBlue PPO (Regional PPO) Enrollment Kit.
2. Contact an authorized independent agent or call one of our licensed representatives to help you determine if this plan is right for you.
3. Enroll one of three ways:
 - Fill out the enrollment form and return it in the postage-paid return envelope
 - Enroll online at www.YourMedicareSolutions.com
 - Call MedicareBlue PPO (Regional PPO) Customer Service at **1-866-434-2038**, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY: **1-866-456-1550**). You have the option to speak with a licensed sales representative when you call

Important Information — Please Read

Please do not mail your enrollment form until November 15, 2009.

Federal guidelines prohibit companies offering Medicare policies from processing applications before this date.

2010 MEDICAREBLUE PPO (REGIONAL PPO) MEDICARE ADVANTAGE PLAN INDIVIDUAL ENROLLMENT FORM

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: **1-866-456-1550**).

A. PERSONAL INFORMATION (Please Print Clearly):

Last Name:		First Name:	Middle Initial:	Mr.	Mrs.	Ms.
Birth Date: (mm/dd/yyyy)	Male	Home Phone Number:		Alternate Phone Number (optional):		
Female						
Permanent Residence Street Address (P.O. Box is not allowed):						


City:		State:	ZIP Code:			
Mailing Street Address (only if different from your Permanent Residence Street Address):						

City:		State:	ZIP Code:			

B. ENROLL ME IN THE PLAN CHECKED BELOW (Monthly Premium Shown):

MedicareBlue PPO (Regional PPO) \$57.30 per month

C. PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> Fill in these blanks so they match your red, white and blue Medicare card exactly. <p style="text-align: center;">- OR -</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	
	<p>Name: _____</p> <p>Medicare Claim Number: _____ Sex: _____</p> <p>_____ - _____</p> <p>Is Entitled To: HOSPITAL (Part A) Effective Date (mm/dd/yyyy): _____</p> <p>MEDICAL (Part B) _____</p>

D. PAYING YOUR PLAN PREMIUM (Also See Section H)

You can pay your monthly plan premium by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month. Once Medicare approves your enrollment, you can change your payment method to Electronic Funds Transfer (EFT). If you would like EFT as your premium payment option, please return the EFT form you'll receive in your welcome kit or contact Customer Service for a 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.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

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 doesn't cover.

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

Get a paper bill. **Do not send a premium payment with this application.**

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take up to three months to begin. You are responsible for all premiums due from your enrollment effective date up to the point withholding begins.)

E. ENROLLMENT PERIOD DETERMINATION

Typically, you may enroll in a Medicare Advantage plan only 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 don't add or drop your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods. Please read the following statements carefully and check the box if the statement 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: A choice of effective dates is only allowed in the enrollment situations identified below.** In all other cases, or if you do not specify an effective date, your effective date will be the first of the month after your form is received by the plan.

I am enrolling during the annual enrollment period, November 15 through December 31, for a **January 1 effective date**

I am enrolling during the Medicare Advantage Open Enrollment Period, January 1 through March 31 (disenrolling from a Medicare Advantage Prescription Drug plan)

I am new to Medicare. My effective date for Medicare is (mm/dd/yyyy) _____

I moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (mm/dd/yyyy) _____. Requested effective date (mm/dd/yyyy) _____

I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums

I get extra help paying for Medicare prescription drug coverage as of (mm/dd/yyyy) _____

I no longer qualify for extra help paying for my Medicare prescription coverage. I stopped getting extra help on (mm/dd/yyyy) _____

I am moving into or live in a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved or will move into the facility on (mm/dd/yy) _____

I am moving out of a Long-Term Care Facility (for example, a nursing home or long-term care facility) on (mm/dd/yy) _____

I left a PACE program on (mm/dd/yyyy) _____

I involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) or was notified of the loss (whichever is later). I lost my drug coverage on (mm/dd/yyyy) _____. Requested effective date (mm/dd/yyyy) _____

I am leaving employer or union coverage on (mm/dd/yyyy) _____. Requested effective date (mm/dd/yyyy) _____

I belong to Big Sky Rx (a state pharmaceutical assistance program) provided by the state of Montana

I returned to the United States after living permanently outside the U.S. I returned to the U.S. on (mm/dd/yyyy) _____

I have disenrolled from a Medicare cost plan and the plan's optional supplemental Part D benefits as of (mm/dd/yyyy) _____

I am being disenrolled from a special needs plan because my condition does not qualify me for that plan as of (mm/dd/yyyy) _____

I am being disenrolled from my existing plan due to its non-renewal or termination as of (mm/dd/yyyy) _____. Requested effective date (mm/dd/yyyy) _____

Other Special Enrollment Period _____

None of these statements apply to me. Please contact MedicareBlue PPO (Regional PPO) Customer Service (the phone numbers are on the front and back covers) to see if you are eligible to enroll.

If you have special needs or need translation of this material into another language, alternative formats are available. Please contact MedicareBlue PPO (Regional PPO) Customer Service at the phone numbers listed on the front of this form.

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 don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't 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 (Regional PPO)? Yes No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other 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 the Institution: _____
Address and Phone Number 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 OF ENROLLMENT FORM AND SIGN BELOW:

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, 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 (Regional 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:** _____

I give permission to the licensed agent identified below to enter my enrollment form online through www.YourMedicareSolutions.com.

Check if you are the authorized representative. You **MUST** sign above and provide the following information:

Name (Print): _____ Phone number: _____
Address: _____ City: _____ State: _____ ZIP Code: _____
Relationship to Enrollee: _____

I want all mail for this member sent to me.

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

Assistant Name (Print): _____ Relationship to Enrollee: _____
Assistant Signature: _____ Today's Date: _____

Check if you are an agent assisting the enrollee to complete this form. **You must sign and date below.**

Agent Name (Print): _____ Agent #: _____ Agency #: _____
Agent Signature: _____ **Today's Date:** _____ Phone #: _____
Check one: ICEP/IEP: _____ OEP: _____ AEP: _____ SEP: _____ (type) _____

H. STOP - PLEASE READ THIS IMPORTANT INFORMATION - STOP

If you currently have health coverage from an employer or union, joining MedicareBlue PPO (Regional PPO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MedicareBlue PPO (Regional PPO). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

After carefully reading all statements in this section, please sign Section G of this form. Keep the copy marked "Enrollee" for your records.

1. I understand MedicareBlue PPO (Regional PPO) is a regional Medicare Advantage plan and has a contract with the Federal government. Coverage is available to residents of the service area and separately issued by one of the following plans: 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.*
*Independent licensees of the Blue Cross and Blue Shield Association
2. I understand that 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 or prescription drug plan. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future.
3. I understand that 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 when an enrollment period is available (example: November 15–December 31 of every year), or under certain special circumstances.
4. I understand that MedicareBlue PPO (Regional PPO) serves a specific service area. If I move out of the area that MedicareBlue PPO (Regional PPO) serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
5. I understand that once I am a member of MedicareBlue PPO (Regional 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 MedicareBlue PPO (Regional PPO) when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
6. 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.
7. I understand that beginning on the date MedicareBlue PPO (Regional 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, MedicareBlue PPO (Regional PPO) provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by MedicareBlue PPO (Regional PPO) and other services contained in my MedicareBlue PPO (Regional PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICAREBLUE PPO (REGIONAL PPO) WILL PAY FOR THE SERVICES.**
8. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and Blue Shield plans offering MedicareBlue PPO (Regional PPO), he/she may be paid based on my enrollment in MedicareBlue PPO (Regional PPO).
9. **Release of Information:** By joining this Medicare health plan, I acknowledge that MedicareBlue PPO (Regional PPO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations and as otherwise permitted by law. I also acknowledge that MedicareBlue PPO (Regional 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.
10. I understand that MedicareBlue PPO (Regional 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 (Regional PPO).
11. If I have ESRD (end-stage renal disease), I cannot enroll in MedicareBlue PPO (Regional 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.



For More Information...

Contact your licensed and certified independent agent

Or call MedicareBlue PPO (Regional PPO) toll-free: **1-866-434-2038**

TTY users should call: **1-866-456-1550**

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

You have the option to speak with a licensed sales representative when you call.

Or visit us on the Web at

www.YourMedicareSolutions.com