Blue Cross Group MedicareRx (PDP)℠

Proposed Effective Date:
__ __ / 0 1 / 2 0 __ __
(Must be after enrollee signature date)

Blue Cross Group MedicareRx℠ Medicare Prescription Drug Plan Retiree Enrollment Form

To enroll in Blue Cross Group MedicareRx, please provide the following information:

Please check the plan you want to enroll in:	Please check the name of your pension fund:
☐ **PDP Plan 1* - $84.10 Per Member Per Month** ☐ **PDP Plan 2** - $ 53.20 Per Member Per Month**	☐ **Laborers & Retirement Board Employees (LABF)** ☐ **Municipal Employees (MEABF)** ☐ **Policemen (PABF)** ☐ **Firemen (FABF)**

Employer: City of Chicago	Group #: BILP0017

Legal LAST Name:	Legal FIRST Name:	Middle Initial (Optional):

Birth Date: __ __ / __ __ / __ __ __ __	Sex: ☐ M ☐ F	Employee ID: __ __ __ __ __ __ __ __ __ __

Home Phone Number: (__ __ __) __ __ __ – __ __ __ __	Alternate Phone Number: (__ __ __) __ __ __ – __ __ __ __

Permanent Residence Street Address (don't enter a PO Box unless you're experiencing homelessness):

City:	County:	State:	ZIP Code: __ __ __ __ __

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

Street Address:	City:	State:	ZIP Code: __ __ __ __ __

Emergency Contact Name:

Phone Number: (__ __ __) __ __ __ – __ __ __ __	Relationship to You:

Member Email Address:

Please Provide Your Medicare Insurance 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.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name (as it appears on your Medicare Card):

Medicare Number:

__ __ __ __ __ __ __ __ __ __ __

Some boxes may be blank.

is Entitled to:	Effective Date:
HOSPITAL (Part A)	
MEDICAL (Part B)	

*To enroll in this plan, you must also enroll in MA Plan 1. **To enroll in this plan, you must also enroll in MA Plan 2.

Applicant LAST name:	FIRST name:

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE, other private insurance, federal employee health benefits coverage, or state pharmaceutical assistance programs) in addition to Blue Cross Group MedicareRx? ☐ Yes ☐ No

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

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

2. 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: _____

Address & Phone Number of Institution (number and street):

_____

All fields in this section are optional:

Select one if you want us to send you information in a language other than English.

☐ **Spanish**

Select one if you want us to send you information in an accessible format.

☐ **Braille** ☐ **Large Print** ☐ **Audio CD** ☐ **Data CD**

Please contact Blue Cross Group MedicareRx at 1-866-390-4276 if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through Sept. 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. TTY users can call 711.

Applicant LAST name:	FIRST name:

Please Read and Sign Below

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

Blue Cross Group MedicareRx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Cross Group MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time — if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Cross Group MedicareRx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan at any time or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Blue Cross Group MedicareRx has a service area that includes the United States and its territories. If I move out of the area that Blue Cross Group MedicareRx serves, I need to notify my Employer Group Benefits Office so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue Cross Group MedicareRx network pharmacies. Once I am a member of Blue Cross Group MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross Group MedicareRx when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber's Employer Group and Blue Cross and Blue Shield of Illinois (BCBSIL), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSIL to use the Blue Cross and/or Blue Shield Service Marks in the State of Illinois, and that BCBSIL is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSIL and that no person, entity, or organization other than BCBSIL shall be held accountable or liable to Subscriber for any of BCBSIL's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSIL other than those obligations created under other provisions of this agreement.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross Group MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross Group MedicareRx 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. 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) on this application means that I have read and understand the contents of this application.
If signed by an authorized individual (as described below), 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.

Applicant LAST name:	FIRST name:

Please Read and Sign Below (continued)	
Signature:	**Today's Date:** ____ ____ / ____ ____ / ____ ____ ____ ____
If you are the authorized representative, you must sign above and provide the following information: Name:	
Address:	
Phone Number: (____ ____ ____) ____ ____ ____ – ____ ____ ____ ____	
Relationship to Enrollee:	

For individuals helping enrollee with completing this form only:

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, authorized representatives, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee:

☐ Agent ☐ Broker ☐ SHIP Counselor ☐ Authorized Representative ☐ Other (third party) ☐ Self

Signature: _____ National Producer Number (Required for Agents/Brokers): _____

Office Use Only:		
Plan ID #:		
☐ ICEP / IEP	☐ AEP	☐ SEP (type):
Name of staff member/agent/broker (if assisted in enrollment):		
LC:		Referral ID:
Subgroup ID #:		Subgroup Description:
Class ID #:		Plan ID #:
Plan Description:		

Applicant LAST name:	FIRST name:

MAIL APPLICATIONS TO:

Blue Cross Group MedicareRx℠
C/O Prescription Drug Plan (PDP) Forms
PO Box 3897
Scranton, PA 18505

Prescription drug plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HCSC's plans depends on contract renewal.

Applicant LAST name:	FIRST name: