Florida Blue

BlueMedicare℠ Group PPO (Employer PPO)

A Medicare Advantage Health Plan for Groups

Employer/Union Group Health Plan Enrollment Form

P.O. Box 45296
Jacksonville, FL 32232-5296

Please contact BlueMedicare Group PPO if you need information in another language or format (e.g., Spanish, Braille, Audio, Large Print).

To Enroll in BlueMedicare Group PPO please provide the following information:

Please check both a Health and Prescription drug plan option:

Health Option: ❍ Essential PPO ❍ Value PPO ❍ Advanced PPO ❍ Platinum PPO ❍ Elite PPO

Prescription Drug Option: ❍ Essential Rx ❍ Value Rx ❍ Advanced Rx ❍ Platinum Rx ❍ Elite Rx ❍ Ultra Rx

Include dental/hearing/vision package : ❍ Yes ❍ No

Full Name of Employer or Union: CITY OF TALLAHASSEE

Group # 45380 Location Code |__|__|__|__| Group Renewal Date |01| |01| |2022| (M M D D Y Y Y Y)

Requested Effective Date of Coverage: |__|__| |01| |01| |__|__|__|__| (M M D D Y Y Y Y) | Employee ID # (if available):

Last Name: | First Name: | Middle Initial: | ❍ Mr. ❍ Mrs. ❍ Ms.

Birth Date: |__|__|__|__|__|__|__|__| (M M D D Y Y Y Y) | Sex: ❍ M ❍ F | Home Phone Number: ( ) | Alternate Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City: | County: | State: | ZIP Code:

Please provide a Mailing address (where all communications except your bill are sent) only if different from your Permanent Residence Address.

Street Address: | City: | State: | ZIP Code:

E-mail 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.

Name (as it appears on your Medicare card):

_____

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 Advantage plan.

Please read and answer these important questions:

1. Are you the retiree? ❍ Yes ❍ No

   If "yes," retirement date?: |__|__| |__|__| |__|__|__|__|
   M M D D Y Y Y Y

   If "no," name of retiree: _____

2. Are you covering a spouse or dependent(s) under this employer or union plan? ❍ Yes ❍ No

   If "yes," name of spouse: _____ Name(s) of dependent(s): _____

   _____

3. Do you or your spouse work? ❍ Yes ❍ No _____

4. Some individuals may have other health and/or drug coverage, including other private insurance, Workers' Compensation, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other **prescription** drug coverage in addition to BlueMedicare Group PPO? ❍ Yes ❍ No

   If "yes," please provide the following information:

   Name of Carrier: _____

   Address: _____ Phone #: _____

   Policy Holder: _____

   Type of Coverage: ❍ Group ❍ Supplemental ❍ Excess ❍ Private (self pay) ❍ Veterans Affairs (VA)

   ID#: _____ Group# (if applicable): _____ Effective Date: _____ Term Date: _____

   Will you have other **health** coverage in addition to BlueMedicare Group PPO? ❍ Yes ❍ No

   If "yes," please provide the following information:

   Name of Carrier: _____

   Address: _____ Phone #: _____

   Policy Holder: _____

   Type of Coverage: ❍ Group ❍ Supplemental ❍ Excess ❍ Private (self pay) ❍ Veterans Affairs (VA)

   ID#: _____ Group# (if applicable): _____ Effective Date: _____ Term Date: _____

5. 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 of Institution (number and street): _____

   Phone Number of Institution: _____

6. Please provide the name of your Physician of Choice (POC), if applicable. A POC is a physician that you choose to see for most health reasons. If you wish to change to a different POC after becoming active in this plan, you may contact our Member Services Department.

POC First Name	POC Last Name	Physician Group Name
_____	_____	_____
POC's FL Blue Provider ID Number		Physician Group's FL Blue Provider ID Number
|___|___|___|___|___| - |___| (ie: 12345 or 12345A)		|___|___|___|___|___| - |___| (ie: 12345 or 12345A)
POC's 10-digit National Provider ID (NPI)		Physician Group's 10-digit National Provider ID (NPI)
Number |___|___|___|___|___|___|___|___|___|___|		Number |___|___|___|___|___|___|___|___|___|___|
Are you currently a patient of this POC? ❍ Yes ❍ No		Are you currently a patient of this Physician Group? ❍ Yes ❍ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ Spanish ☐ Braille ☐ Audio Tape ☐ Large Print

Please contact BlueMedicare Group PPO at 1-800-926-6565 if you need information in an accessible format or language other than what is listed above. TTY users should call 1-800-955-8770. Our office hours are 8 a.m. to 8 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

If you are currently covered under a **Florida Blue Medicare Supplement** policy, do you intend to replace your current coverage with this new Florida Blue Medicare Advantage plan? ❍ Yes ❍ No

❍ By checking here, you request Florida Blue to cancel your **Florida Blue Medicare Supplement** policy on the day before this Medicare Advantage plan becomes effective. For Example, Florida Blue BlueMedicare Group PPO plan is effective July 1st; Florida Blue will cancel your **Florida Blue Medicare Supplement** policy effective June 30th.

To ensure accurate processing, you must provide your **Florida Blue Medicare Supplement** Policy ID Number:

| H | | | | | | | | | - | | | (example: H12345678 - 01).

Please Read and Sign on the Next Page:

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

BlueMedicare Group PPO is a Medicare Advantage plan and has 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage or health coverage that I have or may get in the future. Enrollment in this plan is generally for the entire plan 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: Medicare's Annual Enrollment Period from October 15 - December 7), or under certain special circumstances.

BlueMedicare Group PPO serves a specific service area. If I move out of the area that BlueMedicare Group 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 BlueMedicare Group 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 BlueMedicare Group PPO when I get 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 BlueMedicare Group PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or dialysis services. If medically necessary, BlueMedicare Group PPO provides refunds for all covered benefits, even if I get services out-of-area. Services authorized by BlueMedicare Group PPO and other services contained in my BlueMedicare Group PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without prior authorization when required, **NEITHER MEDICARE NOR BLUEMEDICARE GROUP PPO WILL PAY FOR THE SERVICES AS IN-NETWORK SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BlueMedicare Group PPO, he/she may be paid based on my enrollment in BlueMedicare Group PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that BlueMedicare Group PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueMedicare Group 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. 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.

Signature: _____

Today's Date: |__|__| |__|__| |__|__|__|__|
M M D D Y Y Y Y

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

Name: _____

Address: _____

Phone Number: |__|__|__| – |__|__|__| – |__|__|__|__|

Relationship to Enrollee: _____

Office Use Only:

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

Agent State License #: _____

Florida Blue Agent ID #: _____

Plan ID #: _____

Agent Confirmation #: _____

Effective Date of Coverage: _____

Date Received by Agent: _____

❍ ICEP/IEP ❍ AEP ❍ SEP (type) _____

❍ Not Eligible: _____