MEDICARE ADVANTAGE PLAN CHANGE REQUEST FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

This Plan Change Form can only be used for change from like plan to like plan: HMO to HMO

To make a change in the Medicare Advantage plan you have with Blue Cross Blue Shield of Arizona (AZ Blue) fill out the plan change form to make your choice. Enter the plan information you want below and sign the form.

Changes to health plans can only occur at certain times during the year. From October 15 to December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 to March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

Name of Plan You are Enrolling In:			
LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Member Number:	Home Phone Number:	Cell Phone Number:*	Email Address:*
*Please know by providing your email address, you are agreeing to receive email notifications from us, and by providing your cell phone number, you are agreeing to receive text message notifications from us, as applicable. We will always give you the opportunity to opt-out of future communications.			
Permanent Street Address *(P.O. Box is not allowed):*			
City:	State:	ZIP Code:	County:
Mailing Address *(only if different from your Permanent Street Address):*			
City:	State:		ZIP Code:
Please fill out the following: I am currently a member of the _____ plan in AZ Blue with a monthly premium of $_____. I would like to change to the _____ plan in AZ Blue. I understand that this plan has different health benefits and a monthly premium of $_____.			
Name of chosen Primary Care Provider (PCP), clinic, or health center:			

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

THE 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 Please contact AZ Blue at **1-800-446-8331** if you need information in an accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m., daily from October 1 to March 31, and Monday through Friday from April 1 to September 30. TTY users can call **711.**

PAYING YOUR PLAN PREMIUM AND/OR LATE ENROLLMENT PENALTY

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay AZ Blue the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 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 for this benefit. 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:

☐ Keep my current premium payment option.

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

☐ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

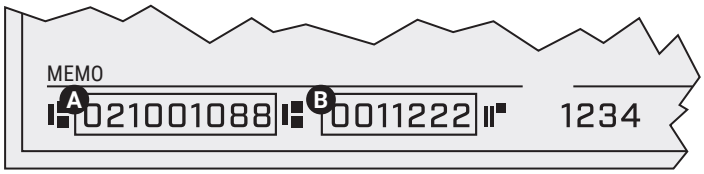
Account holder name: _____

Financial institution: _____

Bank routing number: ☐☐☐☐☐☐☐☐☐

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account type: ☐ Checking ☐ Savings



A The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.

B Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will continue to send you an invoice for your monthly premiums.)

PLEASE READ AND SIGN BELOW

Blue Best Life (HMO) is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with AZ Blue, he/she may be paid based on my enrollment in Blue Best Life (HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Best Life (HMO) 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Best Life (HMO) coverage begins, I must get all of my health care from Blue Best Life (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Best Life (HMO) and other services contained in my Blue Best Life (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE BEST LIFE (HMO) WILL PAY FOR THE SERVICES.**

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: X_____ **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: _____

Office Use Only:

Member ID #: _____ Plan Effective Date: _____ ICEP/IEP: _____ AEP: _____ OEP: _____

SEP: ____ / SEP Reason: _____ Not Eligible: ____ Enrollment Rep: _____ Completed Date: _____

For Use by Agent/Broker:

Certified Agent Name (Print): _____ Agent/Broker #:_____

Broker of Record*: _____ Requested Effective Date: _____

Agent/Broker Signature: _____

Date Received:_____ Phone Number: _____

**Enter the Name of the Entity contracted with AZ Blue*

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-446-8331 (TTY: 711).

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-446-8331 (TTY: 711).

Navajo: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-800-446-8331 (TTY: 711).

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-446-8331 (TTY: 711)。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-446-8331 (TTY: 711).

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-446-8331 (TTY: 711).

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-446-8331 (Người khuyết tật: 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-446-8331 (TTY: 711).

Korean: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-446-8331 (TTY: 711).

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-446-8331 (TTY: 711).

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-446-8331 (TTY: 711).

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-446-8331 (TTY: 711) ।

Farsi (Persian):
همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. توجه: با شماره اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. (TTY: 711 (تله‌تایپ: 1-800-446-8331

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-446-8331 (TTY: 711).

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-446-8331 (TTY: 711)。

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NOTES:

NOTES:

Not a member yet?

Contact our Licensed Medicare Consultants:

1-888-274-0367, TTY: 711

Or contact your broker

Existing Members call:

480-937-0409 (in Arizona)

or toll-free at **1-800-446-8331, TTY: 711**

October 1 to March 31:
Seven days a week, 8 a.m. to 8 p.m.

April 1 to September 30:
Monday through Friday, 8 a.m. to 8 p.m.

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