

Enrollment Request Form



An Independent Licensee of the Blue Cross Blue Shield Association

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1.

The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Blue Cross Blue Shield of Arizona
P.O. Box 29234
Phoenix, AZ 85038

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Blue Best Life (HMO) at **1-888-274-0367**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Blue Best Life (HMO) al **1-888-274-0367**, TTY: **711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

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.

Medicare Advantage (HMO)

Service area: Maricopa County, Pinal County, and Pima County Individual Enrollment Instructions



Please complete the application using a black ballpoint pen.
All sections must be filled out and submitted for enrollment.

Medicare Advantage (HMO) Service area: Maricopa County, Pinal County, and Pima County Individual Enrollment Form



To enroll, please provide all the information requested below.

REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

Maricopa County and Pinal County

- ☐ Blue Best Life Classic (HMO)
\$0 monthly premium (H0302-006)
- ☐ Blue Best Life Select (HMO)
\$0 monthly premium (H0302-010)
- ☐ Blue Best Life Plus (HMO)
\$49 monthly premium (H0302-001)

Pima County

- ☐ Blue Best Life Classic (HMO)
\$0 monthly premium (H0302-008)
- ☐ Blue Best Life Select (HMO)
\$0 monthly premium (H0302-011)

STEPS:

A. Select the plan you wish to enroll in.

B. Provide your Medicare Insurance Information as it appears on your red, white, and blue Medicare I.D. card.

C. Provide all personal information.

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare I.D. 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 and Part B to join a Medicare Advantage plan.

Name: Jane L. Smith

(as it appears on your Medicare card)

Medicare Number X X X X - X X X - X X X X

Is Entitled To Effective Date (MM/DD/YY)
HOSPITAL (Part A) 01 / 01 / 2000
MEDICAL (Part B) 01 / 01 / 2000

FIRST Name: <u>Smith</u>		LAST Name: <u>Jane</u>		Optional: Middle Initial: <u>L.</u>	
Birth Date: <u>06 / 03 / 2033</u> M M / D D / Y Y Y Y		Sex: ☐ M ☒ F	Home Phone Number: <u>(602) 000-0000</u>		Optional: Cell Phone Number*: ()
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):					
City: <u>Phoenix</u>	State: <u>Arizona</u>	ZIP Code: <u>85000</u>	Optional: County: <u>Maricopa</u>		
Mailing Address (only if different from your Permanent Residence Address): (P.O. Box allowed) <u>P.O. Box 56789</u>				Apt or PO Box #: <u>203</u>	
Optional: Email Address*: <u>jane.smith@yahoo.com</u>					
City: <u>Phoenix</u>		State: <u>Arizona</u>		ZIP Code: <u>85000</u>	

*By providing your email address on this page, you are agreeing to receive email notifications from us for any benefit or health education materials, such as the Annual Notice of Change. By providing your cell phone number, you are agreeing to receive text message notifications from us regarding health education or alerts, as applicable. We will always give you the opportunity to opt-out of future communications.

YOUR CHECKLIST

Please read the instructions and statements carefully. Please use this check list to make sure you've completed all required information.

- ☐ **A. WHICH PLAN ARE YOU ENROLLING IN?** – Mark an "X" in the box next to the AZ Blue Medicare plan you wish to enroll in.
- ☐ **B. MEDICARE NUMBER** – Please print your Medicare Number exactly as it is written on your Medicare Health Insurance Card or your letter from Social Security or the Railroad Retirement Board.
- ☐ **C. PERSONAL INFORMATION** –
 - **Name** – Print your name exactly as it appears on your Medicare Health Insurance Card, even if there is an error. Errors need to be corrected with your local Social Security Administration Office. We will be notified of your corrected name by the Centers for Medicare & Medicaid Services (CMS).
 - **Permanent Resident Street Address** – should be your current residence, where you presently live (P.O. Box Address is NOT allowed). You must live within the AZ Blue service area to join this plan.
 - **Mailing Address** (if different from your Permanent Residence) – an address where you receive your mail.
- ☐ **D. PRIMARY CARE PROVIDER** – Please print the First and Last Name of your Primary Care Provider (PCP). If you do not complete this information, your PCP will be automatically assigned for you by the plan.

IMPORTANT INFORMATION – Read each statement carefully. If there is anything you do not understand, please contact AZ Blue at the phone number below, during the hours of operation listed below.

SIGNATURE – By signing your enrollment form, you agree to follow the plan rules and have an understanding of your member responsibilities. If you have any questions, please call us. **Sign your name as it is listed on your Medicare Health Insurance Card, and date the form.** Keep the Enrollment Receipt of the enrollment form for your records. In most cases, we will acknowledge the receipt of your application in writing before the effective date. If someone is assisting you in completing this form, please contact AZ Blue at the telephone numbers listed below for further instructions. If you have a representative that is completing this form on your behalf, your representative must be a Durable General Power of Attorney (DPOA) or court-ordered Legal Guardian to sign this form. Please provide a copy of the paperwork that shows that your representative is your DPOA or Legal Guardian. Lack of proof will not delay the processing of the application.

Mail the Individual Enrollment Form to:

Blue Cross Blue Shield of Arizona
P.O. Box 29234, Phoenix, AZ 85038

Contact us at:

1-888-274-0367, TTY: 711

We are available October 1 – March 31, seven days a week, 8 a.m. to 8 p.m.

(April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m.)

Or, visit our website at **azblue.com/medicare**.

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Medicare Advantage (HMO)

Service area: Maricopa County, Pinal County, and Pima County Individual Enrollment Form



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REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

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\$49 monthly premium (H0302-001)

Pima County

- ☐ Blue Best Life Classic (HMO)
\$0 monthly premium (H0302-008)
- ☐ Blue Best Life Select (HMO)
\$0 monthly premium (H0302-011)

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare I.D. 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 (MM/DD/YY)

HOSPITAL (Part A) _____/_____/_____

MEDICAL (Part B) _____/_____/_____

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

FIRST Name:		LAST Name:		Optional: Middle Initial:	
Birth Date: ____/____/____ M M / D D / Y Y Y Y		Sex: ☐ M ☐ F	Home Phone Number: ()		Optional: Cell Phone Number*: ()
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):					
City:	State:	ZIP Code:	Optional: County:		
Mailing Address (only if different from your Permanent Residence Address): (P.O. Box allowed)					Apt or PO Box #:
Optional: Email Address*:					
City:		State:		ZIP Code:	

*By providing your email address on this page, you are agreeing to receive email notifications from us for any benefit or health education materials, such as the Annual Notice of Change. By providing your cell phone number, you are agreeing to receive text message notifications from us regarding health education or alerts, as applicable. We will always give you the opportunity to opt-out of future communications.

Enrollee Name: _____ Plan Effective Date: _____

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or State pharmaceutical assistance programs in addition to Blue Best Life (HMO).

Will you have other Medicare Prescription Drug Coverage? ☐ Yes ☐ No

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

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

[illegible]

Plan End Date for this coverage: ___ ___ / ___ ___ / ___ ___
M M / D D / Y Y

2. Are you enrolled in your State Medicaid (AHCCCS) program? ☐ Yes ☐ No

If "yes," please provide your Medicaid number: _____

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 (number and street): _____

Enrollee Name: _____ Plan Effective Date: _____

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently 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 (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.

Enrollee Name: _____ Plan Effective Date: _____

- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Blue Best Life Classic, Plus, and Select toll-free at **1-888-274-0367**, TTY users should call **711** to see if you are eligible to enroll. We are open October 1 – March 31, seven days a week, 8 a.m. to 8 p.m., April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m. Or, visit **[azblue.com/medicare](https://www.azblue.com/medicare)**.

Enrollee Name: _____ Plan Effective Date: _____

Do you currently have a Medicare Supplement plan? ☐ Yes ☐ No

☐ I understand I am signing up with a Medicare Advantage Plan with a Part D pharmacy plan. I understand I cannot combine a Medicare Supplement or Medigap plan with a Medicare Advantage plan.

All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

Alternate Contact:

Cell Phone Number:

Relationship to you:

List your Primary Care Provider (PCP), clinic, or health center:

Is this your current Primary Care Provider? ☐ Yes ☐ No

Please note: If you do not provide the name of a PCP, one will be assigned for you by the plan.

Have you recently moved into the service area for the plan you selected above? ☐ Yes ☐ No

If yes, date of move ____/____/____
MM DD YYYY

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Formulary ☐ Provider Directory

Email address: _____

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 Best Life (HMO) at **1-800-446-8331** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., daily from October 1 – March 31, and Monday through Friday from April 1 – September 30. TTY users can call **711**.

Enrollee Name: _____ Plan Effective Date: _____

PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

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

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay AZ Blue the Part D-IRMAA.

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.ssa.gov/medicare/part-d-extra-help.

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.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**Please select premium/late enrollment penalty payment option below
(if you don't select a payment option, you will get a bill each month):**

- ☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Bank name: _____ Account type: ☐ Checking ☐ Savings

Bank routing number: _____ Bank account number: _____

- ☐ Get a monthly bill (You can pay your monthly bill with a check or call us to pay with a credit card)
- ☐ 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, we will send you an invoice until the deductions from Social Security or RRB are approved, which can take two to three months. 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 THIS IMPORTANT INFORMATION & SIGN BELOW

If you currently have health coverage from an employer or union, joining Blue Best Life (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Best Life (HMO). 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.

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

1. Blue Best Life (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I must keep both Hospital (Part A) and Medical (Part B) to stay in a Blue Best Life (HMO) plan. I understand that I can be enrolled in only one Medicare Advantage plan at a time and that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans) or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. 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: October 15 – December 7 of every year**), or under certain special circumstances.
2. Blue Best Life (HMO) serves a specific service area. If I move out of the area that Blue Best Life (HMO) 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 Blue Best Life (HMO), 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 Best Life (HMO) 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.
3. 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 AZ Blue.
 - I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Best Life (HMO).
 - By joining this Medicare Advantage Plan, I acknowledge that Blue Best Life (HMO) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on page 10). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
 - I understand that when my Blue Best Life (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Blue Best Life (HMO). Benefits and services provided by Blue Best Life (HMO) and contained in my Blue Best Life (HMO) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Best Life (HMO) will pay for benefits or services that are not covered.
 - 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 legally 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 representative (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 Medicare



PLEASE READ THIS IMPORTANT INFORMATION & SIGN BELOW

For individuals helping enrollee with completing this form only

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

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]

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*

Enrollee Name: _____

2027 Enrollment Receipt

Please use this as your temporary proof of coverage until Medicare has confirmed your enrollment, and you receive your member ID card. **This receipt is not a guarantee of enrollment.**

This copy is for your records only. Please do not resubmit enrollment.

Fill out this plan recap with your Licensed Sales Representative (if applicable). It will take you through some plan details to help you better understand your new plan.

Here are some details about your new plan:

Enrollee Name:									
Application Date:	My plan coverage begins (effective date):								
My new plan name is: <table border="0"><tr><td>Maricopa County and Pinal County</td><td>Pima County</td></tr><tr><td>☐ Blue Best Life Classic (HMO) \$0 monthly premium (H0302-006)</td><td>☐ Blue Best Life Classic (HMO) \$0 monthly premium (H0302-008)</td></tr><tr><td>☐ Blue Best Life Select (HMO) \$0 monthly premium (H0302-010)</td><td>☐ Blue Best Life Select (HMO) \$0 monthly premium (H0302-011)</td></tr><tr><td>☐ Blue Best Life Plus (HMO) \$49 monthly premium (H0302-001)</td><td></td></tr></table>		Maricopa County and Pinal County	Pima County	☐ Blue Best Life Classic (HMO) \$0 monthly premium (H0302-006)	☐ Blue Best Life Classic (HMO) \$0 monthly premium (H0302-008)	☐ Blue Best Life Select (HMO) \$0 monthly premium (H0302-010)	☐ Blue Best Life Select (HMO) \$0 monthly premium (H0302-011)	☐ Blue Best Life Plus (HMO) \$49 monthly premium (H0302-001)	
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☐ Blue Best Life Plus (HMO) \$49 monthly premium (H0302-001)									
My plan type is: ☐ HMO	RxBIN: 610011 RxPCN: CTRXMEDD RxGRP: BAZMAPD								
Premium Information: My plan has a: \$ _____ monthly premium. I understand I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me. If I owe a Late Enrollment Penalty (LEP), it is not included in my premium and I will need to add it to my premium each month.									
I must live in the plan's service area. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.									
I can cancel my enrollment in this plan before my coverage starts by calling Member Services at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331 (TTY users should call 711). We are open October 1 – March 31, seven days a week, 8 a.m. to 8 p.m.; April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m. Once my coverage starts, I may have to wait until the Annual Enrollment Period (Oct 15 – Dec 7) to make a plan change, unless I qualify for a Special Election Period.									
Call your Licensed Sales Representative if you have any questions:									
Licensed Sales Representative Name and ID Number	Licensed Sales Representative Phone No.								

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

[illegible]



An Independent Licensee of the Blue Cross Blue Shield Association