Enrollment Instructions

CareFirst Medicare Advantage

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** 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:

CareFirst BlueCross BlueShield Medicare Advantage,
Attn: Sales Department
P.O. Box 915, Owings Mills, MD 21117

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

How do I get help with this form?

Call CareFirst BlueCross BlueShield Medicare Advantage at 1-844-331-6334. 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 CareFirst BlueCross BlueShield Medicare Advantage al 1-844-331-6334 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 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.

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SECTION 1—ALL FIELDS IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

◯ **DualPrime** • $0–$28.20 per month (Based on your level of "Extra Help")

FIRST Name:	LAST Name:	Middle Initial (optional):

Birth Date (MM/DD/YYYY):	Sex: ◯ Male ◯ Female	Home Phone Number:	Mobile Phone (optional):

Email Address: (optional)

I authorize the health plan to text and email me helpful reminders, articles and tips on healthy living, surveys, and general information about the plan. I understand that I may opt-out of receiving these messages by contacting Member Services at 1-844-386-6762 (TTY: 711), 8 a.m.–8 p.m., ET, 7 days a week from Oct. 1–Mar. 31 and 8 a.m.–8 p.m., ET, Monday–Friday from Apr. 1–Sept. 30.

◯ **Yes, I would like to receive messages** ◯ **No, I do not want to receive messages**

Permanent Residence Street Address **(Don't enter a PO Box)**:			Apt. Number:
City:	County (optional):	State:	ZIP Code:

Mailing Address, if different from your Permanent Address Street Address **(PO Box allowed)**:		Apt. Number:
City:	State:	ZIP Code:

YOUR MEDICARE INFORMATION

Medicare Number:	Part A Effective Date:	Part B Effective Date:

ANSWER THESE IMPORTANT QUESTIONS

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareFirst BlueCross BlueShield Medicare Advantage? ◯ Yes ◯ No

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

2. Are you enrolled in your State Medicaid program? ◯ Yes ◯ No

If yes, provide 11-digit Medicaid number:

To be eligible for Dual Prime, you must have a Medicaid level of Qualified Medicare Beneficiary (QMB) or Full Benefit Dual Eligible (FBDE).

3. Are you a resident of a long-term facility, such as a nursing home? ◯ Yes ◯ No

If "yes," name of Facility:	Phone number of Facility:

Address of Facility:

INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD

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 this information is incorrect, you may be disenrolled.

	I am new to Medicare.
	I am making a change during the Annual Enrollment Period (AEP) from October 15 to December 7.
	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 to March 31.
	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 both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
	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) _____.
	I belong to a pharmacy assistance program provided by my state.
	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.
	I am enrolled in a plan that has been identified with the low performing icon (LPI).
	I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1–March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.
	I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).

INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD

If none of these statements applies to you or you're not sure, please contact CareFirst BlueCross BlueShield Medicare Advantage at **844-331-6334 (TTY: 711)** to see if you are eligible to enroll. We are open October 1 through March 31, seven days a week from 8 a.m. – 8 p.m., and April 1 through September 30, Monday through Friday from 8 a.m. – 8 p.m.

SECTION 2—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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ◯ No, not of Hispanic, Latino/a, or Spanish origin
- ◯ Yes, Mexican, Mexican American, Chicano/a
- ◯ Yes, Puerto Rican
- ◯ Yes, Cuban
- ◯ Yes, another Hispanic, Latino/a, or Spanish origin
- ◯ **I choose not to answer.**

What's your race? Select all that apply.

- ◯ American Indian or Alaska Native
- ◯ Asian
  - ◯ Asian Indian
  - ◯ Chinese
  - ◯ Filipino
  - ◯ Japanese
  - ◯ Korean
  - ◯ Vietnamese
  - ◯ Other Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Pacific Islander
  - ◯ Guamanian or Chamorro
  - ◯ Native Hawaiian
  - ◯ Samoan
  - ◯ Other Pacific Islander
- ◯ White
- ◯ **I choose not to answer**

1. 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 ◯ Large print

   Please contact CareFirst BlueCross BlueShield Medicare Advantage at 1-844-386-6762 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. – 8 p.m ET, 7 days a week, October 1 – March 31; 8 a.m. – 8 p.m. ET, Monday – Friday, April 1 - September 30. TTY users should call 711.

2. Do you work? ◯ Yes ◯ No Does your spouse work? ◯ Yes ◯ No

3. Please choose the name of a Primary Care Physician (PCP). Refer to the plan website or Provider & Pharmacy Directory to choose.

PCP Name:	PCP Address:

Are you now seeing or have you recently seen this doctor? ◯ Yes ◯ No

PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month**.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. 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. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. Don't pay CareFirst BlueCross BlueShield Medicare Advantage 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 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 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.

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

Please select a premium payment option:

- ○ Get a bill by mail
- ○ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name:	Bank routing number:
Bank account number:	Account type: ○ Checking ○ Saving

- ○ 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 send you a paper bill for your monthly premiums.)

IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareFirst BlueCross BlueShield Medicare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that CareFirst BlueCross BlueShield Medicare Advantage 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 below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time—and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my CareFirst BlueCross BlueShield Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareFirst BlueCross BlueShield Medicare Advantage. Benefits and services provided by CareFirst BlueCross BlueShield Medicare Advantage and contained in my CareFirst BlueCross BlueShield Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareFirst BlueCross BlueShield Medicare Advantage 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.

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 and 1860D-1 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.

Signature:	Today's Date:
If you're the authorized representative, sign above and fill out these fields	
Name:	Address:
Phone Number:	Relationship to Enrollee:

Agent Use Only		
Agent Name:	Agent ID:	
Initial Receipt Date:	Proposed Effective Date of Coverage:	LIS Level:

CareFirst BlueCross BlueShield Medicare Advantage is an HMO-SNP Plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Medicare Advantage depends on contract renewal.

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage DSNP Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.