2020 Enrollment Request for

Medicare PLUS Blue℠ Group PPO

UAW Retirees of Daimler Trucks North America
60911-600
<BCBSM ID #>

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please provide the following information. Please print.

☐ Mr. ☐ Mrs. ☐ Ms.	**First Name**	**M.I.**	**Last Nam**

Date of birth (mm/dd/yyyy) _____/____/_____	**Sex** ☐ Male ☐ Female	**Daytime phone number** ( )	**Alternate phone number** ( )

Permanent residence address *(cannot be a post office box)*	**City**	**State**

Zip Code	**County**	**E-mail address (optional)**

Mailing address *(if different from your permanent residence address)*

Street Address_____

City_____ State_____ Zip Code_____

OPTIONAL INFORMATION

Emergency contact name_____

Relationship to you Telephone Number ( )

Please take out your red, white and blue Medicare Health Insurance card to complete this section.

Please fill in these blanks so they match the information on your Medicare card.

OR

Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

_____

MEDICARE CLAIM NUMBER

_____-_____-_____-_____

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL (PART A)	_____-_____-_____
MEDICAL (PART B)	_____-_____-_____

Medicare Plus Blue is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

Please respond to all questions	
1. **Do you have other drug coverage, including other private insurance, workers compensation, VA benefits or state pharmaceutical assistance programs?** If yes, please provide: Company name: _____ Name of other drug plan: _____ ID/policy number for this coverage: _____	☐ **Yes** ☐ **No**
2. **Are you a resident of a long-term care facility, such as a nursing home?** If yes, please provide: Name of facility: _____ Facility street address: _____ City_____ State_____ Zip Code_____ Phone number: (_____)_____	☐ **Yes** ☐ **No**
3. **Do you have end stage renal disease (ESRD)?** If you answered yes and no longer need regular dialysis or have had a successful kidney transplant, **please attach a note or records** from your doctor verifying that you do not need dialysis or have had a successful kidney transplant.	☐ **Yes** ☐ **No**
4. **Are you enrolled in Medicaid?** If yes, please provide your Medicaid number:_____	☐ **Yes** ☐ **No**
5. **Please enter the name of your primary doctor:** _____	**Primary doctor's telephone:** **( )**
Please contact Medicare Plus Blue Customer Service at 1-866-684-8216 (TTY users call 711) if you need information in an alternate format or need assistance in a language other than English. Customer Service hours are 8:30 a.m. to 5 p.m. Monday through Friday (October 1 through February 14, 8 a.m. to 8 p.m., seven days a week). You can also visit us at **www.bcbsm.com**.	

Please read and sign below	
Signature	**Today's date** (mm/dd/yyyy)

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

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone number (___) _____

Relationship to enrollee _____

Please send your completed enrollment application to:

UAW Retirees of Daimler Truck
Fund Office
P.O. Box 4447
Troy, MI 48099

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

Medicare Plus Blue Group PPO is a health plan with a Medicare contract. I will need to keep my Parts A and B. I can only be in 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 Medicare Prescription Drug Plan. If the Medicare Advantage plan has a Medicare Prescription Drug Plan, enrollment in the Medicare Advantage PPO plan will automatically end my enrollment in another Medicare Prescription Drug Plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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, or under certain special circumstances.

As a Medicare Advantage PPO, Medicare Plus Blue Group PPO works differently than a Medicare supplemental plan. Medicare Plus Blue Group PPO pays instead of Medicare, and I will be responsible for the amounts that Medicare Plus Blue Group PPO does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in Medicare Plus Blue Group PPO.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will or my out-of-pocket costs may be greater.

Medicare Plus Blue Group PPO serves a specific service area. If I move out of the area that Medicare Plus Blue 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 Medicare Plus Blue 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 Medicare Plus Blue Group PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage Preferred Provider Organization plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

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

Release of Information: By joining this Medicare Advantage PPO health plan, I acknowledge that the 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 Medicare Plus Blue Group PPO will release my information, including my prescription drug event data, to Medicare, which may release it for research and other purposes that 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 behalf of the individual under the laws of the state where the individual resides) 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 by Medicare Plus Blue Group PPO or by Medicare.