



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 12625  
Salem, OR 97309-0625  
1-888-REGENCE  
(1-888-734-3623)  
1 (800) 382-1003 (TTY)

# Regence MedAdvantage Enrollment Request Form

● PLEASE PRINT IN INK ●

Important Information	
Please check which plan you want to enroll in:	
<input type="checkbox"/>	Regence MedAdvantage + Rx Enhanced (medical and Rx plan) \$123.00
<input type="checkbox"/>	Regence MedAdvantage + Rx Classic (medical and Rx plan) \$107.00
<input type="checkbox"/>	Regence MedAdvantage + Rx Core (medical and Rx plan) \$39.00
<input type="checkbox"/>	Regence MedAdvantage (medical only plan) \$78.00

Name (Last )	(First)	(M.I.)
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Birthdate (mm/dd/yyyy)	Sex	Social Security Number (providing this information is optional)	Medicare Number
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Telephone Number (including area code)	E-mail address
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Your Permanent Residence Address			
Number	Street	Apartment	

City	County	State	ZIP Code (+4)
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Your Mailing Address (if different from Permanent Address)			
Number	Street	Apartment	

City	County	State	ZIP Code (+4)
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Emergency Information		
Name of relative or friend other than spouse	Telephone Number	Relationship to you

Office Use Only					
Effective Date	Election Type	Group #	Pkg #	Alt. ID #	Agent #

## Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)?  Yes  No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other **prescription** drug coverage in addition to Regence MedAdvantage?  Yes  No

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

Name of other coverage \_\_\_\_\_

ID Number for this coverage \_\_\_\_\_

Group Number for this coverage \_\_\_\_\_

Rx BIN Number \_\_\_\_\_ Rx PCN Number \_\_\_\_\_


3. Do you or your spouse work?  Yes  No

4. Are you currently enrolled in a Regence BlueShield of Idaho individual medical plan or Medicare supplement plan?  Yes  No

If yes, do you wish to terminate that coverage?  Yes  No

**If you answered "yes" to both of the above questions, please sign the statement below:**

I, \_\_\_\_\_ wish to terminate my  
coverage from \_\_\_\_\_ effective on the date of  
this Regence MedAdvantage policy.

Signature  \_\_\_\_\_ Date \_\_\_\_\_

Please check the box below, if you would prefer us to send your information in another format:

Large print, audio tape or CD

Please contact Regence MedAdvantage at 1-800-541-8981 (TTY users should call 1-800-382-1003) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m. seven days a week.

# STOP

## Please read this important information

**If you currently have health coverage from an employer or union, joining Regence MedAdvantage + Rx Core, Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced could affect your employer or union health benefits.**

If you have health coverage from an employer or union, joining Regence MedAdvantage + Rx Core, Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

### **Paying Your Plan Premium:**

**You can pay your plan premium by mail each month or quarterly or by having it deducted from your bank account. You can also choose to pay your premium by automatic deduction from your Social Security check each month.**

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 does not cover.

**Please select one plan premium payment option below.** If you don't select a payment option, you will receive a bill each month.

**Would you like us to automatically deduct your premium from your bank account?**  Yes  No  
**(A completed SurePay form is required.)**


OR

**Would you like us to bill you monthly or quarterly?**  Monthly  Quarterly

OR

**Automatic deduction from your monthly Social Security benefit check.** (The Social Security deduction will begin approximately two months after your enrollment date. We will bill you for your premium until the Social Security deduction begins.)  Yes  No

### **Agent Use Only**

Agent Name \_\_\_\_\_ Agent Signature  \_\_\_\_\_  
(Please print)

Agent Number \_\_\_\_\_ Agent Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
(including area code)

**Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage.** Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

**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 recently moved outside of the service area for my current plan.
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for Medicare prescription drugs.
- I live in or recently moved out of a long term care facility (for example, a nursing home or long term care facility). **Please provide the following information:**

Name of Institution \_\_\_\_\_

Address and Phone Number of Institution (number and street) \_\_\_\_\_

- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I am leaving employer or union coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- None of these statements applies to me.\*

\* Please contact Regence MedAdvantage at 1-800-541-8981 (TTY users should call 1 -800-382-1003) to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., seven days a week.

## **Please read and sign on page 5**

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

Regence BlueShield of Idaho MedAdvantage is a Medicare Advantage plan and has a contract with the Federal government. 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 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 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: November 15 - December 31 of every year), or under certain special circumstances.

**(Important: Signature required on page 5)**

