

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 benefit check each month.

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 are eligible for these savings and don't even know it. For more information about this extra help, contact your 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.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. 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 one plan premium payment option below.

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)



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 don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't 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 CD Audio Tape

Please contact Regence MedAdvantage at 1-800-541-8981 (TTY users should call 711) 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 from November 15 through March 1. After March 1 our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day.



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 don't add or drop your prescription drug coverage (i.e., if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the annual enrollment 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 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for my Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____
- 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) _____

Please provide the following information:

Name of Institution _____

Address and Phone Number of Institution (number and street)

- I recently left a PACE program on (insert date) _____
- I recently involuntarily lost my creditable prescription drug 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.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____
- None of these statements applies to me.*

* Please contact Regence MedAdvantage at 1-800-541-8981 (TTY users should call 711) 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 from November 15 through March 1. After March 1 our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day.



STOP

Please read this important information

If you currently have health coverage from an employer or union, joining Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign on page 6

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 Medicare 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 don't 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.

Regence MedAdvantage serves a specific service area. If I move out of the area that Regence MedAdvantage 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 Regence MedAdvantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Regence MedAdvantage when I get it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Regence MedAdvantage coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Regence MedAdvantage provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Regence MedAdvantage and other services contained in my Regence MedAdvantage Evidence of Coverage document will be covered. Without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE WILL PAY FOR THE SERVICES.

(Important: Signature required on page 6)




Please read and sign below

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Regence MedAdvantage, he/she may be paid based on my enrollment in Regence MedAdvantage. This compensation does not affect my premium in any way.

Counseling services may be available in my state to provide advice concerning Medicare supplement 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 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 Regence MedAdvantage 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. I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give Medicare or their agents the information needed to run the Medicare program. 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 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 by Regence MedAdvantage or by Medicare.

Your Signature*  _____ Date _____
month/day/year

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

Name _____ Relationship to enrollee _____

Address _____ Phone Number _____

