



## 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 BlueCross BlueShield of Oregon 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 \_\_\_\_\_

**STOP**  
**Please read this important information**

**If you currently have health coverage from an employer or union, joining Regence MedAdvantage + Rx 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 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 SSA benefit check.** (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)  Yes  No

**Agent Use Only - (The following is a required disclosure to the potential enrollee.)**

The person that is discussing plan options with you is either employed by or contracted with Regence. The person may be compensated based on your enrollment in a plan. This compensation does not affect your premium in any way.

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

Agent Signature  \_\_\_\_\_

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. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements and check the box to the left of the statement that applies to you. We will contact you for additional information.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I was recently approved for extra help paying for Medicare prescription drug coverage.
- I just moved "into" a Long Term Care Facility (for example, a nursing home or long term care hospital). **Please provide the following information:**

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

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

- I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare's).
- I am either losing coverage I had from an employer or leaving employer coverage.
- None of the above statements apply to me.

If you are not sure if any of the above statements applies to you, please contact us to see if you are eligible to enroll.

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

## Please read and sign below

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

Regence BlueCross BlueShield of Oregon MedAdvantage is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. 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. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Regence MedAdvantage or by calling 1-800-MEDICARE, 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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 Regence MedAdvantage Evidence of Coverage document from Regence MedAdvantage when I receive 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 my Regence MedAdvantage coverage begins, I can go to doctors, specialists or hospitals in or out-of-the-network. I also understand that I may have to pay more for out-of-network services. I understand that services authorized by Regence MedAdvantage and other services contained in my Regence MedAdvantage plan Evidence of Coverage document will be covered. I also understand that without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE WILL PAY FOR THE SERVICES.**

**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 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 Regence MedAdvantage or by Medicare.

Your Signature\*  \_\_\_\_\_ Date      /      /       
month/day/year

\* If you are the authorized representative, you must provide the following information:

Name \_\_\_\_\_ Relationship to enrollee \_\_\_\_\_

Address \_\_\_\_\_ Phone Number (      ) \_\_\_\_\_