

# Enrollment Request Form

## 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](https://www.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:

**BlueCare Plus Tennessee**

**ATTN: BlueCare Plus Tennessee Enrollment**  
**1 Cameron Hill Circle, Suite 0006**  
**Chattanooga, TN 37402-0006**

Once we process your enrollment request form, we'll contact you.

## How do I get help with this form?

Call BlueCare Plus Tennessee at **1-888-413-9637**.

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 BlueCare Plus Tennessee al **888-413-9637**, TTY **711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

### IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

**Section 1 – All fields on this page are required (unless marked optional)****Select the BlueCare Plus Tennessee plan you want to join:**☐ BlueCare Plus (HMO D-SNP)<sup>SM</sup>

Must be enrolled in BlueCare Tennessee (Medicaid Program), excluding CHOICES

☐ BlueCare Plus Choice (HMO D-SNP)<sup>SM</sup>

Must be enrolled in both BlueCare Tennessee (Medicaid Program) and CHOICES LTSS or Employment and Community First CHOICES.

☐ BlueCare Plus Select (HMO D-SNP)<sup>SM</sup>

FIRST name:

LAST name:

[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY)

( \_\_\_\_ / \_\_\_\_ / \_\_\_\_ )

Sex:

☐ Male ☐ Female

Phone number:

( \_\_\_\_ )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

[Optional: County]:

State:

ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address:

City:

State:

ZIP Code:

**Your Medicare information:****Medicare Number:**    \_ \_ \_ \_ - \_ \_ \_ - \_ \_ \_ \_**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueCare Plus Tennessee?

☐ Yes (If Yes, you must provide the information below.)☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you enrolled in your State Medicaid program?

☐ Yes (If Yes, please provide your Medicaid number.)☐ No

Your Medicaid number: \_\_\_\_\_

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueCare Plus Tennessee.
- By joining this Medicare Advantage Plan, I acknowledge that BlueCare Plus Tennessee 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 plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my BlueCare Plus Tennessee coverage begins, I must get all of my medical and prescription drug benefits from BlueCare Plus Tennessee. Benefits and services provided by BlueCare Plus Tennessee and contained in my BlueCare Plus Tennessee “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueCare Plus Tennessee 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.

**Signature:**

**Today’s date:**

If you’re the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

## 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.

Select one if you want us to send you information in a language other than English. ☐ Spanish ☐ Arabic

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact BlueCare Plus Tennessee at **1-800-332-5762** if you need information in an accessible format other than what's listed above. Our office hours are from **Oct. 1 to March 31**, you can call us from 8 a.m. to 9 p.m. ET, seven days a week. From **April 1 to Sept. 30**, we're available from 8 a.m. to 9 p.m. ET, Monday through Friday. TTY users can call **711**.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No?

List your Primary Care Physician (PCP), clinic, or health center:

I want to get available materials via:

☐ email email address: \_\_\_\_\_

☐ text mobile phone number: \_\_\_\_\_

**Note:** By checking the above boxes, I agree to enroll in email and/or mobile text communication and that I'm 18 or older or the legal guardian or personal representative of the applicant. BlueCross, its affiliates and its service providers may send me email and/or text communications that also go out to other members at the same time. Unencrypted email or text messages may possibly be intercepted and read by people other than those it's addressed to. By providing my email address, I accept the risks associated with emailing. Message and data rates may apply

## Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail. 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 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. DON'T pay BlueCare Plus Tennessee the Part D-IRMAA.

## For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to enrollee: Select one. (Agents/Brokers must include NPN)

- ☐ Agent National Producer Number (Agents/Brokers only): \_\_\_\_\_
- ☐ Broker
- ☐ SHIP counselors
- ☐ Authorized representatives
- ☐ Other (third parties)
- ☐ Self

### Licensed Agent Use Only

I certify that I have truly and accurately recorded on this application the information supplied by the enrollee.

Licensed agent: \_\_\_\_\_ Agent ID #: \_\_\_\_\_ Date received: \_\_\_\_\_

Plan ID #: \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not eligible: \_\_\_\_\_

## 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.

BlueCare Plus Tennessee is an HMO D-SNP plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in BlueCare Plus Tennessee depends on contract renewal.

# Attestation of Eligibility for an 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 that this information is incorrect, you may be disenrolled.

- |  |   |
|--|---|
| <input type="checkbox"/> I am new to Medicare.   | <input type="checkbox"/> I recently left a PACE program on (insert date) _____ .  |
| <input type="checkbox"/> I am making my annual enrollment period election (October 15 through December 7).   | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ .  |
| <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).   | <input type="checkbox"/> I am leaving employer or union coverage on (insert date) _____ .   |
| <input type="checkbox"/> 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) _____ .   | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.  |
| <input type="checkbox"/> I recently was released from incarceration. I was released on (insert date) _____ .   | <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.   |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ .   | <input type="checkbox"/> 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) _____ .  |
| <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ .   | <input type="checkbox"/> 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) _____ .  |
| <input type="checkbox"/> 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) _____ .  | <input type="checkbox"/> I was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster. |
| <input type="checkbox"/> 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) _____ .        | <input type="checkbox"/> I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.   |
| <input type="checkbox"/> 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) _____ . | <input type="checkbox"/> I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.   |

- 
- ☐ I requested Medicare information in an accessible format. I got less time to make my decision, or I didn't get it in time to make a choice before my enrollment period ended.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ Because of an exceptional circumstance, I had a Special Enrollment Period and signed up for either:
- › Premium-Part A (Hospital Insurance) and Part B (Medical Insurance)
  - › Only Premium-Part A (I already have Part B)
  - › Only Part B (I already have Part A and don't pay a premium for it)
- I want to join a Medicare Advantage Plan (with or without drug coverage) because I now have both Part A and Part B.
- ☐ 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.
- ☐ None of these statements apply to me.

---

Please contact **BlueCare Plus Tennessee** at **1-888-413-9367, TTY 711**, to see if you are eligible to enroll.

---

From **Oct. 1 to March 31**, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.

BlueCare Plus Tennessee, an Independent Licensee of the Blue Cross Blue Shield Association