Group Plan 65®

Member Enrollment Request Form

Please be sure to complete ALL information below to avoid delays in processing.

Section 1 – Employer Information (To be completed by plan administrator.)

Group Name	Effective Date ____/____/____ MM / DD / YYYY
Group #	Subgroup #

Section 2 – Please Provide Personal Information (Please Print)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date ____/____/____ MM / DD / YYYY	Sex Assigned At Birth ☐ M ☐ F	Home Phone Number ( )	Cell Phone Number ( )

Social Security Number* ____-____-______ XXX - XX - XXXX	I am a current BCBSRI Member ☐ Yes ☐ No	Current BCBSRI ID (if applicable)

Primary Language
Permanent Residence Street Address (P.O. Box is not allowed)

City	State	ZIP Code

Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

Email Address

*Social Security is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/mandatory-Insurer-Reporting-For-Group-Health-Plans/

Section 3 - Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare card to complete this section.
Fill out this information exactly as it appears on your Medicare card.

Name	
Medicare number	

Is entitled to: Effective Date:

Hospital (Part A) ______________________________

Medical (Part B) ______________________________

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

Are you under 65 and eligible for Medicare coverage due to a disability?

❒ Yes ❒ No

Section 4 - Please Provide Your Current or Prior Insurance Information

What is the name of your current or prior health insurance carrier?	When will your coverage terminate? ______/______/______ MM / DD / YYYY
______________________________	Please attach a copy of your Certificate of Creditable Coverage showing the coverage end date, unless you are enrolled with BCBSRI or are new to Medicare Part B. **Application will not be processed until received.**

Section 5 - Eligibility

Please read the “Important Information” section. Then answer questions 1-7.

a. You do not need more than one Medicare Supplement policy.

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

c. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

d. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

e. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your

employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

f. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

To the best of your knowledge:

1. Do you have another Medicare Supplement insurance policy or certificate in force? ☐ Yes ☐ No
   If yes, with which insurer? ____
   If yes, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
2. Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy? ☐ Yes ☐ No
   If yes, with which insurer? ____
   Address of Insurance company: ____
   What kind of policy? ____
   Name of policyholder: ____
   Relationship: ____
   Policy/Contract #: ____
   Name of employer who offers this coverage: ________________________________
3. Do you have a Medicare Advantage policy? ☐ Yes ☐ No
   If yes, with which insurer? ____
4. Are you covered by medical assistance through the state Medicaid program? ☐ Yes ☐ No
   a. As a Specified Low-income Medicare Beneficiary (SLMB)? ☐ Yes ☐ No
   b. As a Qualified Medicare Beneficiary (QMB)? ☐ Yes ☐ No
   c. For other Medicaid medical benefits? ☐ Yes ☐ No
5. Are you transferring from an out-of-state Medicare Supplement plan? ☐ Yes ☐ No
6. If yes, please include: the name, state, and type of Medicare Supplement plan:
   Name: ____
   State: ____
   Type: ____
   Subscriber ID: ____
7. Have you received the Notice of Replacement Coverage? ☐ Yes ☐ No

Section 6 - Please Read and Sign Below

By completing this enrollment application, I certify and agree that:

By signing this form, I certify the information is true and complete to the best of my knowledge.

Signature: ____ **Today's Date:** ____________________

Internal Use Only – To Be Completed by Agent

<table>
<tr><th colspan="6">Internal use only – To be completed by Agent</th></tr>
<tr><td>Application Code</td><td>☐ NEW: Member is New to BCBSRI</td><td>☐ TCONV: Existing BCBSRI member (commercial)</td><td>☐ NCONV: Value of Blue 1- Elected BCBSRI MA as first MA election</td><td>☐ NCONV2: Value of Blue 2 – Moved from supplement to BCBSRI MA</td><td>☐ AEP: Annual Enrollment Plan A only</td></tr>
<tr><td colspan="4">Sales Agent Signature (if assisted in enrollment)</td><td colspan="2">Agent Received Date</td></tr>
<tr><td colspan="4">Print Sales Agent Name</td><td colspan="2">Broker ID#</td></tr>
<tr><td colspan="4">Effective Date of Coverage:</td><td colspan="2"></td></tr>
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