Independence
Keystone 65 Preferred HMO

INDIVIDUAL ENROLLMENT
NON-GROUP ELECTION FORM

Please contact Independence Blue Cross if you need information in another language or format (Braille).

A To Enroll in Keystone 65 Preferred HMO, Please Provide the Following Information:

Please check the box next to the plan you wish to enroll in:

Keystone 65 Preferred HMO

	(Counties: Chester, Delaware, Montgomery)	*(Counties: Philadelphia, Bucks)*
☐ Medical Only (No Rx) 044 and 008	Monthly Premium $224.00	Monthly Premium $178.00
☐ Medical with Rx 045 and 020	$289.00	$229.00

LAST Name: FIRST Name: Middle Initial:

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)

Sex: ☐ M ☐ F

☐ Mr. ☐ Mrs. ☐ Ms.

Home Phone Number: ( )

Email Address (optional)**:** _____

By voluntarily giving Independence Blue Cross my phone number (including my mobile number) and/or email address, I authorize Independence Blue Cross and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via email, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy.

Permanent Residence Address (P.O. Box is not allowed): County:

Street Address: City: State: ZIP Code:

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

Street Address: City: State: ZIP Code:

Emergency Contact: _____

Phone Number: _____ Relationship to You: _____

B Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To: Effective Date:

HOSPITAL (Part A) (__ __/__ __ /__ __ __ __)
(M M/ D D / Y Y Y Y)

MEDICAL (Part B) (__ __/__ __ /__ __ __ __)
(M M/ D D / Y Y Y Y)

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

C Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Keystone 65 Preferred HMO the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the 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 local 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 a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Account type: ☐ Checking

Bank account number: _____ ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

D Please read and answer these important questions:

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

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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 Keystone 65 Preferred HMO? ☐ Yes ☐ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes," please provide the following information:
Name of Institution: _____
Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

Please check any of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Other language (please specify) _____
☐ Braille
☐ Audio tape

Please contact Independence Blue Cross if you need information in another format or language than what is listed above. Call toll-free 1-877-393-6733 (TTY/TDD: 711), seven days a week, 8 a.m. to 8 p.m. Please note on weekends and holidays from February 15 through September 30, your call may be sent to voicemail.

E Please Choose Your Providers

Primary Care Physician (check box if current physician) ☐	Physician Code No./Group ID _____ The 9-digit number beneath provider name in directory

F 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.

☐ 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 recently was released from incarceration. I was released on (insert date) _____ .

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ .

F Attestation of Eligibility for an Enrollment Period

- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ I get Extra Help paying for 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) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (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.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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) _____.

If none of these statements applies to you or you're not sure, please contact Independence Blue Cross at 1-877-393-6733 (TTY users should call toll-free 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. Please note on weekends and holidays from February 15 through September 30, your call may be sent to voicemail.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Keystone 65 Preferred HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Keystone 65 Preferred HMO. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any contact information, your benefits administrator or the office that answers questions about your coverage can help.

G Please Read and Sign Below

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

Keystone 65 offers HMO plans with a Medicare contract. Enrollment in Keystone 65 Medicare Advantage plans depends on contract renewal. 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: October 15 - December 7 of every year), or under certain special circumstances.

Keystone 65 Preferred HMO serves a specific service area. If I move out of the area that Keystone 65 Preferred HMO 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 Keystone 65 Preferred HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Keystone 65 Preferred HMO when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

G Please Read and Sign Below Continued

I understand that beginning on the date Keystone 65 Preferred HMO coverage begins, I must get all of my health care from Keystone 65 Preferred HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Keystone 65 Preferred HMO and other services contained in my Keystone 65 Preferred HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KEYSTONE 65 PREFERRED HMO WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Independence Blue Cross, he/she may be paid based on my enrollment in Keystone 65 Preferred HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that Keystone 65 Preferred HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Keystone 65 Preferred HMO will release my information, including my prescription drug event data to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations. 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 from Medicare.

Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

You must continue to pay your Medicare Part B premium.

Signature:	**Today's Date:** (__ __/__ __ /__ __ __ __) (M M / D D / Y Y Y Y)

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

Name: _____

Address: _____

Phone Number: (____) _____ - _____

Relationship to Enrollee: _____

Office Use Only

Name of agent/broker (if assisted in enrollment): _____

Agent/broker signature:_____ Date application received: _____

Plan ID #:_____ Effective Date of Coverage: _____

ICEP/IEP:_____ AEP:_____ SEP (type):_____ Not Eligible:_____

Agent Number (NIPR/NPN)_____ General Agency Number_____ FMO ID _____