53517

Independence
Keystone 65 HMO

2021 Benefits & Information Change Form

Name of Plan you are enrolling in:

Name: | **Medicare Number:**

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 Street Address (P.O. Box is not allowed):
Street Address: City: State: ZIP Code:

Mailing Address (only if different from your Permanent Street Address):
Street Address: City: State: ZIP Code:

Please fill out the following: I am currently a member of the _____ plan in Independence Blue Cross. I would like to change to the plan indicated below. I understand that this plan has different health benefits and a different monthly premium, as shown below.

Choose **ONE** of the plans below by placing a check mark ✔ in the box ❑. For more information on coinsurance, copayments, deductibles, and limitations for each plan, see your Summary of Benefits and/or Evidence of Coverage.

Plan Name	Counties: Chester, Delaware, Montgomery	Counties: Philadelphia, Bucks
Keystone 65 Basic Rx HMO (056 and 055)	❑ $0	❑ $0
Keystone 65 Focus HMO-POS Rx (054 and 053)	❑ $15.00	❑ $0
Keystone 65 Select Medical Only (050 and 048)	❑ $49.50	❑ $34.50
Keystone 65 Select Rx (051 and 049)	❑ $82.50	❑ $56.50
Keystone 65 Preferred Medical Only (044 and 008)	❑ $194.00	❑ $178.00
Keystone 65 Preferred Rx (045 and 020)	❑ $258.00	❑ $230.00

Name of chosen Primary Care Physician (PCP), clinic or health center: _____

Physician Code No./Group ID: _____

Your Plan Premium

For Keystone 65 HMO in Chester, Delaware, Montgomery, Philadelphia, and Bucks counties, if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium (including any late enrollment penalty you 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 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 the Railroad Retirement Board. Do NOT pay Keystone 65 HMO the Part D-IRMAA.

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 coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. 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 ❑ Pay directly on ibxpress.com

❑ EFT from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: ☐☐☐☐☐☐☐☐☐ Account type:

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐☐ ❑ Checking ❑ Savings

❑ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security 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.)

STOP **Please Read This Important Information.**

Please Read and Sign Below:

Keystone 65 offers HMO plans with a Medicare contract. Enrollment in Keystone 65 Medicare Advantage plans depends on contract renewal.
You must continue to pay your Medicare Part B premium.
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 HMO.
Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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

❑ Spanish ❑ Braille or audio

Please contact Keystone 65 HMO at 1-800-253-4083 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. (TTY/TDD users should call 711). Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

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 Keystone 65 HMO will release my information, including my prescription drug event data to Medicare, which may release it for research and other purposes which 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

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.

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 staff member/agent/broker (if assisted in enrollment): _____

Plan ID #:_____ Effective Date of Coverage:_____

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