



**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](http://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.

<input type="checkbox"/> Personal Choice 65 <sup>SM</sup> Prime with Rx (014 and 015)	\$0 (Bucks/Philadelphia counties) \$0 (Chester/Delaware/Montgomery counties)
<input type="checkbox"/> Personal Choice 65 Saver with Rx (016)	\$0 (Bucks/Philadelphia counties) \$0 (Chester/Delaware/Montgomery counties)
<input type="checkbox"/> Personal Choice 65 Elite with Rx (017)	\$51 (Bucks/Philadelphia counties) \$51 (Chester/Delaware/Montgomery counties)
<input type="checkbox"/> Personal Choice 65 <sup>SM</sup> Medical Only (007)	\$179.00 (Bucks/Philadelphia counties)
<input type="checkbox"/> Personal Choice 65 <sup>SM</sup> with Rx (001 and 009)	\$294.00 (Bucks/Philadelphia counties) \$165.00 (Chester/Delaware/Montgomery counties)

**Name of chosen Primary Care Physician (PCP), clinic or health center: (optional)** \_\_\_\_\_ **Physician Code No./Group ID:** \_\_\_\_\_

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 Personal Choice 65 PPO 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.

**Your Plan Premium**

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 Personal Choice 65 PPO 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/TDD users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://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.)



**Please Read This Important Information.**

**Please Read and Sign Below:**

Personal Choice 65 offers PPO plans with a Medicare contract. Enrollment in Personal Choice 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 Personal Choice 65 PPO.

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

**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 Personal Choice 65 PPO 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 Personal Choice 65 PPO coverage begins, using services in-network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Personal Choice 65 PPO provides refunds for all covered benefits, even if I get services out of network. Without authorization, **NEITHER MEDICARE NOR PERSONAL CHOICE 65 PPO 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: \_\_\_\_\_