Florida Blue | MEDICARE

P.O. Box 45296, Jacksonville, FL 32232-5296

A Medicare Advantage Health Care Plan for Groups

Employer/Union Group Health Plan Enrollment Form

Please check a Health and Prescription drug plan option:

○ Advanced PPO with Advanced Rx ○ Platinum PPO with Platinum Rx ○ Elite PPO with Elite Rx

Include dental/hearing/vision package: ○ Yes ○ No

Full Name of Employer or Union:

CITY OF TALLAHASSEE

Group #:	Location Code:	Group Renewal Date:
45380		01 01 2027

Requested Effective Date of Coverage:	Employee ID # (if available):
01 Y	

First Name:	Last Name:	Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Mobile Phone Number:
M D	○ M ○ F	( )	( )

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

City:	County:	State:	ZIP Code:

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

Street Address:	City:	State:	ZIP Code:

By providing a telephone number(s), you confirm that you are the subscriber and/or authorized user of the phone numbers, provided and you consent to receive calls and text messages at those number(s) from, and on behalf of, Blue Cross and Blue Shield of Florida, Inc., Florida Blue Medicare, Inc., and their affiliates, including calls and texts using an automated telephone dialing system, prerecorded or artificial voice messages, or both. The types of calls and texts you consent to receive include messages about your plan and benefits, messages about servicing your account, and healthcare-related and informational messages that are not for marketing purposes. You may revoke your consent at any time. Message and data rates may apply. Message frequency varies. Major carriers supported. Our Terms of Use and Privacy Policy also apply and are available online at floridablue.com.

Please provide your Medicare insurance information:

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

Medicare Number:	Part A Effective Date:	Part B Effective Date:
		Y

OMB No. 0938-1378 Expires: 12/31/2027

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

Language: ○ Spanish

Accessible Format (Select One): ○ Braille ○ Large Print ○ Audio CD ○ Data CD

Please contact BlueMedicare Group PPO at 1-800-926-6565 (TTY: 711) if you need information in an accessible format or language other than what is listed above. Our hours are 8 a.m. to 8 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Please read and answer these important questions:

1. Are you a retiree? ○ Yes ○ No

   If "yes," retirement date?: M M D D Y Y Y Y

   If "no," name of retiree: _____

2. Are you covering a spouse or dependent(s) under this employer or union plan? ○ Yes ○ No

   If "yes," name of spouse: _____

   Name(s) of dependent(s): _____

   _____

3. Do you or your spouse work? ○ Yes ○ No

4. Will you have other **prescription** drug coverage in addition to BlueMedicare Group PPO? ○ Yes ○ No

   If "yes," please provide the following information:

   Name of Carrier: _____

   Address: _____ Phone #: (_____) _____ – _____

   Policy Holder: _____

   Type of Coverage:

   ○ Group ○ Supplemental ○ Excess ○ Private (self pay) ○ Veterans Affairs (VA)

   ID#: _____ Group# (if applicable): _____ Effective Date: _____ Term Date: _____

5. Will you have other **health** coverage in addition to BlueMedicare Group PPO? ○ Yes ○ No

   If "yes," please provide the following information:

   Name of Carrier: _____

   Address: _____ Phone #: (_____) _____ – _____

   Policy Holder: _____

   Type of Coverage:

   ○ Group ○ Supplemental ○ Excess ○ Private (self pay) ○ Veterans Affairs (VA)

   ID#: _____ Group# (if applicable): _____ Effective Date: _____ Term Date: _____

6. 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 of Institution (number and street): _____

Phone Number of Institution: (_____) _____–_____

7. Please provide the name of your Physician of Choice (POC), if applicable. A POC is a physician that you choose to see for most health reasons. If you wish to change to a different POC after becoming active in this plan, you may contact our Member Services Department.

POC First Name: _____ POC Last Name: _____ POC's FL Blue Provider ID Number |_|_|_|_|_|_| (ie: 12345 or 12345A) POC's 10-digit National Provider ID (NPI) Number: |_|_|_|_|_|_|_|_|_|_| Is enrollee currently a patient of this POC? ○ Yes ○ No	Physician Group Name: _____ Physician Group's FL Blue Provider ID Number |_|_|_|_|_|_| (ie: 12345 or 12345A) Physician Group's 10-digit National Provider ID (NPI) Number: |_|_|_|_|_|_|_|_|_|_| Is enrollee currently a patient of this Physician Group? ○ Yes ○ No

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If you are currently covered under a **Florida Blue Medicare Supplement** policy, do you intend to replace your current coverage with this new Florida Blue Medicare Advantage plan? ○ Yes ○ No

○ By checking here, you request Florida Blue to cancel your **Florida Blue Medicare Supplement** policy on the day before this Medicare Advantage plan becomes effective. For Example, Florida Blue BlueMedicare Group PPO plan is effective July 1st; Florida Blue will cancel your **Florida Blue Medicare Supplement** policy effective June 30th.

To ensure accurate processing, you must provide your **Florida Blue Medicare Supplement** Policy ID Number: |H|_|_|_|_|_|_|_|_| - |_|_| (example: H12345678 - 01).

Please Read and Sign Below. By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueMedicare Group PPO.
- I understand that my 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).
- 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 are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that when my BlueMedicare Group PPO coverage begins, I must get all of my medical and prescription drug benefits from BlueMedicare Group PPO. Benefits and services provided by BlueMedicare Group PPO and contained in my BlueMedicare Group PPO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueMedicare Group PPO will pay for benefits or services that are not covered.
- BlueMedicare Group PPO serves a specific service area. If I move out of the area that BlueMedicare Group PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

- **Release of Information:** By joining this Medicare health plan, I acknowledge that BlueMedicare Group PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
- I also acknowledge that BlueMedicare Group PPO 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).
- I understand that my signature (or the signature of the person legally 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:** _____

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: _____ **Relationship to Enrollee:** _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

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 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.

Email Communications

Email is a great way to stay in touch. Enter your email below to opt-in to receive email messages. We will send you a verification message after you enroll. Once verified, we will send you important information about your plan and other information, including how to set-up your on-line account and how to opt-in to paperless communications.

These communications may contain Protected Health Information (PHI) that is protected by applicable law and by providing your email address you agree and understand that communications may be unencrypted, and you agree to accept the risk that unencrypted electronic communications may be intercepted and/or read by a third party. You agree that you are solely responsible for the accuracy, privacy, and security of the email addresses provided. You also agree to the Privacy Policy and Platform Terms of Use found at https://www.floridablue.com/disclaimer/privacy and https://www.floridablue.com/disclaimer/terms.

E-mail: _____

Medicare Prescription Payment Plan Participation (Completion of this section is optional.)

○ Yes, I would like to participate in the Medicare Prescription Payment Plan.

- I understand this section is a request to participate in the Medicare Prescription Payment Plan. BlueMedicare Group PPO will contact me if they need more information.
- I understand that signing below means I have read and understand this section and the "Terms and Conditions" below.
- BlueMedicare Group PPO will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active. Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature: _____

Today's Date: ☐☐ ☐☐ ☐☐☐☐

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

Name: _____

Address: _____

Phone Number: (_____) _____–_____ **Relationship to Enrollee:** _____

Terms and Conditions

- The program is free to join, there are no fees or interest charged under the program, and the program does not lower the amount of cost-sharing you owe for your Part D prescriptions.
- If you qualify for Low Income Subsidy (LIS), enrollment in LIS is more advantageous than participation in the Medicare Prescription Payment Plan.
- You may opt out of the program at any time. If you opt out, you will still be responsible for paying any remaining balance.
- It is important to pay your bill monthly. Your participation in the Medicare Prescription Payment Plan will be terminated if you fail to pay your monthly billed amount before the end of the grace period.
- If you are disenrolled voluntarily or involuntarily from our Part D plan you will also be terminated from the Medicare Prescription Payment Plan. If you enroll in a different plan, you may opt into the Medicare Prescription Payment Plan under your new plan.
- We cannot require you to answer questions about or provide documentation to prove your ability to pay your Medicare Prescription Payment Plan balance as a condition of you participating in the Medicare Prescription Payment Plan. We also cannot obtain a copy of your credit report from a consumer reporting agency.
- The Part D appeals and grievance procedures will apply to the Medicare Prescription Payment Plan and are located in the Evidence of Coverage.

Office Use Only:	
Name of staff member/agent/broker (if assisted in enrollment): <<AgentName>>	Date Received by Agent: _____
Plan ID #: _____	Florida Blue Agent ID #: <<AgentID>>
Effective Date of Coverage: _____	Agent State License #: _____
ICEP/IEP: _____	Agent Confirmation #: _____
AEP: _____	
SEP (type): _____	
Not Eligible: _____	