University of California

2016 Enrollment Request Form Blue Shield of California Medicare Rx Plan (PDP) Employer Group/Union Prescription Drug Benefit Plan

This form is for Medicare-eligible retirees and their Medicare-eligible dependents who want to enroll in the Blue Shield of California Medicare Rx Plan, a University of California-sponsored Group Prescription Drug Benefit plan.

To enroll, please fill in all the information requested below. Read the terms and conditions on page 3, and then sign and date.

Employer group or union name University of CA

Are you the ☐ Retiree? ☐ Spouse of the retiree? ☐ Other family member?

If retiree, retirement date (month/date/year) ________________________

If not retiree, name of retiree ___________________ Retiree Social Security number __________________

Check which Medical Plan you are requesting

☐ Blue Shield of California Medicare Rx Plan (PDP) with PPO Medical Plan, Group Plan PDPSB001

☐ Blue Shield of California Medicare Rx Plan (PDP) with High Option Plan, Group Plan PDPSB002

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.

Requested future effective date of coverage (__ __/__ __/__ __ __ __) (MM / DD / Y Y Y Y)	Generally the effective date of enrollment will be the first of the month following the Blue Shield enrollment receipt date – unless a future date is requested.

Birth date (__ __/__ __/__ __ __ __) (MM / DD / Y Y Y Y)	Sex ☐ M ☐ F	Home phone number	Alternate phone number

Permanent residence required (no P.O. boxes accepted)
Street address

City	State	ZIP code

Mailing address (only if different from your permanent residence address, P.O. box accepted)
Street address

City	State	ZIP code

Emergency contact (optional)	Relationship to you (optional)	Phone number (optional)

E-mail address (optional)

☐ I am willing to receive required plan materials via e-mail (i.e., enrollment notifications, the Annual Notice of Changes and *Evidence of Coverage* and plan newsletter) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.

Not checking the boxes above means you will received printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

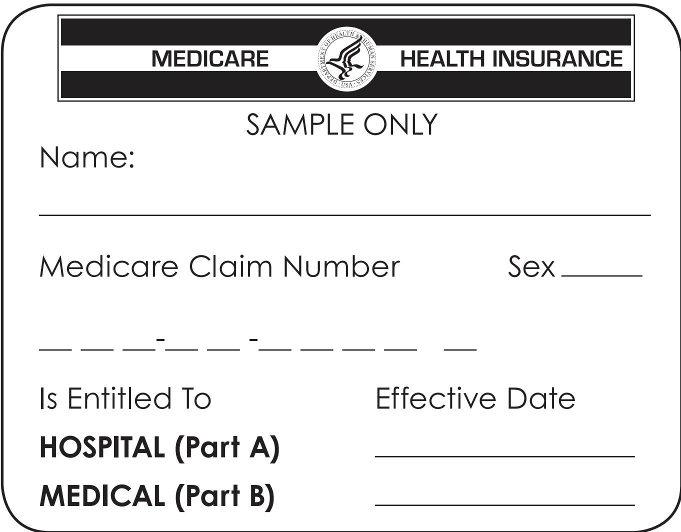
Please provide your Medicare insurance information

- Please fill in these blanks so they match your red, white, and blue Medicare card.

– OR –

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

CMS requires you have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan. However, if you are eligible for premium-free Medicare Part A, UC requires you to have both Medicare Part A and B to join these PDP plans. If you pay a premium for Medicare Part A, contact UC for your coverage options.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ______________________________

Medicare Claim Number Sex ______

___ ___ ___-___ ___-___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) ______________

MEDICAL (Part B) ______________

Please read and answer these important questions

1. Is the UC retiree covering a spouse or dependent(s) under this employer group or union plan?

☐ Yes ☐ No

If yes, name of spouse* ______________________________

Name of dependent(s)* ______________________________

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* If your spouse or any of the covered dependents listed above are eligible for Medicare, please ensure that each complete and return an enrollment form.

2. Does the retiree or spouse work? ☐ Yes ☐ No

3. 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 the Blue Shield of California Medicare Rx Plan? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage

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Name of other coverage ______________________________

ID No. for this coverage ______________________________

Group No. for this coverage ______________________________

4. 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) ______________________________

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Phone number of institution

Please contact Blue Shield of California Medicare Rx Plan at **(888) 239-6469** [TTY **711**] if you need information in another format or language. Our office hours are 7 a.m. to 8 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays.

Please read this important information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining the Blue Shield of California Medicare Rx Plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining the Blue Shield of California Medicare Rx Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Shield of California Medicare Rx Plan. Read the communications your employer or union send you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

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

Blue Shield of California Medicare Rx Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage.

It is my responsibility to inform Blue Shield of California Medicare Rx Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at any time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Shield of California Medicare Rx Plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available (for example, during your former employer group/union's open enrollment period or during the Medicare Annual Enrollment Period, from October 15 through December 7), unless I qualify for certain special circumstances.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Blue Shield of California Medicare Rx Plan network pharmacies. Once I am a member of the Blue Shield of California Medicare Rx Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Blue Shield of California Medicare Rx Plan when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Blue Shield of California Medicare Rx Plan, he/she may be paid based on my enrollment in the Blue Shield of California Medicare Rx Plan.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the State Medicaid program and the Medicare Savings Program.

Release of information

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx Plan will release my information, including my prescription drug event data, to Medicare, who 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 my signature (or the signature of the person authorized to act on my behalf under State law 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 by Medicare.

Enrollee signature ______________________ Today's date ____________

If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information

Name	Address
Phone number	Relationship to enrollee

Please return your completed enrollment forms to:

White copy:
RASC
Retiree Insurance Program
P.O. Box 24570
Oakland, CA 94623-1570
Fax: **(510) 465-9037**

Pink copy:
Keep this copy for your records.

Medicare Prescription Drug Plan Use Only:

Plan ID No. ______________________ NIPR# ____________

Effective Date of Coverage ____________ IEP ________ AEP ________ SEP (type) ________

Plan Representative/Agent/Broker Signature ______________________

Blue Shield of California is an independent member of the Blue Shield Association
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