Florida Blue
Your local Blue Cross Blue Shield

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 both a Health and Prescription drug plan option:

Health Option: ○ Essential PPO ○ Value PPO ○ Advanced PPO ○ Platinum Rx ○ Elite PPO ○ Ultra PPO

Prescription Drug Option: ○ Essential Rx ○ Value Rx ○ Advanced Rx ○ Platinum Rx ○ Elite Rx ○ Ultra Rx

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

Full Name of Employer or Union:

The City of Tallahassee

Group #:	Location Code:	Group Renewal Date:
45380		01 01 2024

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

First Name: Last Name: Middle Initial:

Birth Date:	Sex:	Home Phone Number:	Alternate Phone Number:
MM DD YYYY	○ 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 the telephone number(s) above, you agree to receive calls about your account and non-marketing healthcare-related and informational calls to the number(s) provided, including calls that may use automated technologies and without regard to state or federal limitations on the frequency of calls or messages. If you do not wish to receive autodialed, prerecorded, or artificial voice calls to your mobile number, please contact us at 1-800-926-6565.

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:
	MM DD YYYY	MM DD YYYY

OMB No. 0938-1378 Expires: 07/31/2024

Ethnicity and Race (Optional)

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ○ No, not of Hispanic, Latino/a, or Spanish origin
- ○ Yes, Puerto Rican
- ○ Yes, another Hispanic, Latino/a, or Spanish origin
- ○ **I choose not to answer.**
- ○ Yes, Mexican, Mexican American, Chicano/a
- ○ Yes, Cuban

What's your race? Select all that apply.

- ○ American Indian or Alaska Native
- ○ Chinese
- ○ Japanese
- ○ Other Asian
- ○ Vietnamese
- ○ **I choose not to answer.**
- ○ Asian Indian
- ○ Filipino
- ○ Korean
- ○ Other Pacific Islander
- ○ White
- ○ Black or African American
- ○ Guamanian or Chamorro
- ○ Native Hawaiian
- ○ Samoan

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:

○ Spanish ○ Braille, audio, large print

Please contact BlueMedicare Group PPO at 1-800-926-6565 if you need information in an accessible format or language other than what is listed above. TTY users should call 1-800-955-8770. 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:** _____

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 and 1860D-1 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.

Text Messages

Text messages are a great way to stay in touch, manage your account, and learn more about your plan and benefits.

Opt-in below by adding a mobile number and agreeing to the text messaging terms. We will send you a confirmation text message after you are enrolled to complete your registration to receive member messages and alerts. By opting-in, you consent to receive texts from Florida Blue, its affiliates, and others acting on their behalf at the mobile number provided, including messages using automated technologies and without regard to state or federal limitations on the frequency of calls or messages. Message frequency varies and message and data rates apply. These communications may contain Protected Health Information (PHI) that is protected by applicable law and by opting-in 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 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.

○ **I want to receive text messages and alerts and agree to the terms and conditions stated and referenced above.**

Mobile Number: (_____) _____–_____

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: _____

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