ENROLLMENT APPLICATION

INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.
By completing this enrollment application, I agree to the following:

I understand that Freedom Blue PPO, will notify me in writing of my confirmed effective date of enrollment in Freedom Blue PPO. I understand that, typically, my effective date will be the first of the month following the month in which Freedom Blue PPO receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in Freedom Blue PPO.

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Freedom Blue PPO is a Medicare Advantage Plan and has a contact with the Federal government. I will need to keep my Medicare Parts A and Part B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. 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 by mail or Electronic Funds Transfer (EFT) each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or late enrollment penalty. Many people are eligible 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 on-line 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. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this Plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under special circumstances.

Once I am a member of Freedom Blue PPO, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Freedom Blue PPO when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that the Freedom Blue PPO marketing materials, such as the Summary of Benefits, present only highlights of plans and options, not details.
I acknowledge and agree that any “protected health information” (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Shield’s Notice of Privacy Practices is available on Highmark Blue Shield’s Web site, or from the Highmark Blue Shield Privacy Department.

I understand and agree that any “protected health information” (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Shield’s Notice of Privacy Practices is available on Highmark Blue Shield’s Web site, or from the Highmark Blue Shield Privacy Department.

Please return the top copy of both pages of the application and keep the bottom copies for your records.
TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex  | Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth

Home Phone (with area code) | Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.
• Please fill in these blanks so they match your red, white and blue Medicare card.
  – AND –
• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (Part A):

MEDICAL (Part B): You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Are you currently enrolled in another Medicare Advantage plan? (Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.) ................................. Yes  □ No  □

2. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ................................................. Yes  □ No  □

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 by Freedom Blue PPO or by Medicare.

Signature: _____________________________  Date: _____________________________

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex  | Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth

Home Phone (with area code) | Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.
• Please fill in these blanks so they match your red, white and blue Medicare card.
  – AND –
• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

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HOSPITAL (Part A):

MEDICAL (Part B): You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

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1. Are you currently enrolled in another Medicare Advantage plan? (Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.) ................................. Yes  □ No  □

2. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ................................................. Yes  □ No  □

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 by Freedom Blue PPO or by Medicare.

Signature: _____________________________  Date: _____________________________