# 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.

Please contact Freedom Blue PPO at 1-866-456-7739 (TTY users should call 711 to inquire about materials on audio CD or for telephone translation services). Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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 contract 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 online 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.

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (CONTINUED)

I understand that beginning on the date Freedom Blue 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, Freedom Blue PPO provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in my Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM BLUE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Freedom Blue PPO, he/she may be paid based on my enrollment in Freedom Blue PPO.

## RELEASE OF INFORMATION:

By joining this Medicare health plan, I acknowledge that Freedom Blue PPO will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Freedom Blue PPO 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.

## PERSONAL HEALTH INFORMATION

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.

## PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

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 or Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay Freedom Blue PPO the Part D-IRMAA.

HIGHMARK®

| Former Employer Complete This Section | |
|---|---|
| Employer's Signature and Date: | Effective Date: |

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

| First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ☐ Male ☐ Female |
|---|---|---|---|---|

| 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.

–OR–

- 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.

**YOU WANT TO ENROLL IN:**

☒ 178428

The Pennsylvania State University

**OTHER INSURANCE**

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? . . . . . Yes ☐ No ☐
   If YES, name of plan: _____
2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? Self: . . . . . Yes ☐ No ☐
   Spouse: . . . Yes ☐ No ☐
   Your Retirement Date (Month/Day/Year):_____ Spouse's Retirement Date (Month/Day/Year):_____
3. 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 ☐

**If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.**

## READ AND ANSWER THESE IMPORTANT QUESTIONS

**Please choose the name of a Primary Care Provider (PCP), clinic or health center.**

| Name of Provider (recommended) | PCP/NPI # (from the enclosed Provider Directory) |
|---|---|

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer.
Please check here to receive your provider directory in CD-ROM. ☐

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 ☐

Do you have End-Stage Renal Disease? .....Yes ☐ No ☐
If YES, then you are not eligible to enroll UNLESS you are already a non-Medicare Highmark Blue Shield member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Are you enrolled in your State Medicaid program? .....Yes ☐ No ☐
If "YES," please provide your Medicaid Number: _____

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 and Phone Number of Institution (number and street): _____

**STOP! You may belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.**

## READ AND SIGN BELOW

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 | Today's Date |
|---|---|
| | |

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

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

**Please return the top copy of both pages of this form and keep the bottom copies for your records.**

# Other Insurance Addendum

If you answered YES to having any other Health Insurance or Prescription Drug coverage, please complete and return this form with your application. If you answered NO, you do not need to complete or return this form.

Name _____ Medicare Number _____

**Please specify the type of insurance:**
☐ Active Employer Group Insurance
☐ Retiree Coverage
☐ Veteran's Administration Coverage
☐ Direct Pay Policy
☐ Federal Black Lung Coverage
☐ Supplemental Coverage
☐ Workman's Compensation Coverage

**Please specify type of coverage:**
☐ Medical Only
☐ Medical with Prescription Drugs
☐ Dental or Vision Only
☐ Prescription Drug Only

**Is this insurance provided by:** ☐ Your Employer ☐ Your Spouse's Employer ☐ Individual Plan

**Does your employer have:** ☐ 1-19 employees ☐ 20-99 employees ☐ more than 100 employees

**Does your spouse's employer have:** ☐ 1-19 employees ☐ 20-99 employees ☐ more than 100 employees

**Your employer's name:** _____ **Your insurance name:** _____

**Your insurance policy #:** _____ **Your insurance group #:** _____

**Spouse's employer's name:** _____ **Spouse's insurance name:** _____

**Spouse's insurance policy #:** _____ **Spouse's insurance group #:** _____

Member's Signature* _____ Date _____

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized to under State law to complete this form and 2) documentation of this authority is available upon request by the plan or Medicare.

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

**Name:** _____ **Address:** _____

**Phone:** _____ **Relationship to Enrollee:** _____

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