

OFFICE USE ONLY			
Date Received:	Rep Code:	Group Number:	Effective Date:
Agent Number:	Agency Number:	Applicant present: <input type="checkbox"/>	



A Medicare Advantage Private Fee-for-Service Program

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association

## ENROLLMENT APPLICATION

Please contact FreedomBlue PFFS at 1-866-730-4142 (TTY users should call 1-800-227-8210) to inquire about materials on audio CD or for telephone translation services or if you have questions when filling out this application. Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

### (1) Information About You (Please fill in your name *exactly* as it appears on your Medicare card.)

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex <input type="checkbox"/> Male <input type="checkbox"/> 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)			

(2) Medicare Information	(3) FreedomBlue PFFS Plan Selection (check one)
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Please fill in your claim number and effective dates *exactly* as they appear on your Medicare Card, or attach a copy of your Medicare Card, or your confirmation letter of Medicare eligibility.

Medicare	Health Insurance
SAMPLE ONLY	
Name _____	Sex _____
Medicare Claim Number _____	
Is Entitled To _____	Effective Date _____
<b>HOSPITAL (Part A)</b> _____	
<b>MEDICAL (Part B)</b> _____	

You must have Medicare Part A & Part B to join a Medicare Advantage Plan.

Choice  Choice Plus

### (4) Plan Premium Payment Option

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security (SSA) Check each month. 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 does not cover. If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

Receive a bill. Information about EFT will be included with your first bill.

Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

### (5) Other Insurance

1. Will either you or your spouse be employed once enrolled in FreedomBlue PFFS? Self: Yes  No   
Spouse: Yes  No

Your Retirement Date (Month/Day/Year): \_\_\_\_\_ Spouse's Retirement Date (Month/Day/Year): \_\_\_\_\_

2. Will you have any Health Insurance and/or Prescription Drug Coverage other than FreedomBlue PFFS 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.

**STOP! If you currently have health care coverage from an employer or union, joining FreedomBlue PFFS could affect your employer or union health benefits. If you have health coverage from an employer or union, joining FreedomBlue PFFS may change how your current coverage works. You and your dependents could lose your other health or drug coverage completely and not get it back if you join FreedomBlue PFFS.**

**If you have questions, visit their Web site or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.**

**(6) Please Answer The Following Questions**

Are you currently enrolled in another Medicare Advantage plan? (*Confirmed enrollment in FreedomBlue PFFS 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 member or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area. Please note: if you had a kidney transplant and no longer need dialysis to maintain your life, then you may enroll in FreedomBlue PFFS.

**Please attach a note or records from your doctor if you no longer need dialysis or have had a successful kidney transplant.**

Are you enrolled in your State Medicaid program? (*This does not affect your eligibility to enroll.*) Yes  No   
If you answered YES, please give your Medicaid Number: \_\_\_\_\_

Are you currently a resident in a Medicare or Medicaid certified institution?  
(e.g. Skilled Nursing Facility, Rehabilitation Hospital - - *This does not affect your eligibility to enroll.*) Yes  No   
If you answered YES, please provide the following information:

Name of Institution: \_\_\_\_\_

Address of Institution (number and street): \_\_\_\_\_

Phone number of Institution: \_\_\_\_\_ Date you were admitted to the Institution: \_\_\_\_\_

**(7) Statements Of Understanding And Authorization**

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application, **including the Statements of Understanding and Authorization and Personal Health Information that appear on the back of this application**, and that the information provided by me is accurate and complete. 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 FreedomBlue PFFS or by Medicare.

**Your signature is required in order to process this application.**

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

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

**Please return top copy of this form and keep the pink copy for your records.**

## Statements of Understanding and Authorization

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

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.

### (1) **Effective Date:**

I understand that FreedomBlue PFFS will notify me in writing of my confirmed effective date of enrollment in FreedomBlue PFFS. I understand that, generally, my effective date will be the first of the month following the month in which FreedomBlue PFFS 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 FreedomBlue PFFS.

### (2) **Medicare Eligibility and Medicare Premiums:**

FreedomBlue PFFS is a Medicare Private Fee-For-Service plan that has a contract with the Federal government. I understand that I must be entitled to Medicare Part A and enrolled in Part B to be eligible to join FreedomBlue PFFS. I also understand that I must keep my Medicare Part A and Part B insurance by paying the Part B premiums and the Part A premiums, if applicable.

### (3) **Medicare Advantage Plan Selection:**

I understand that I can be a member of only one Medicare Advantage plan at a time. By enrolling in the plan on this form, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member. I also understand that since I can be a member of only one Medicare Advantage plan at one time, I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage.

### (4) **Voluntary Disenrollment:**

Enrollment in FreedomBlue PFFS and other Medicare Advantage Plans is generally for the entire year. Once I enroll, I may leave this Plan or make changes only at certain times of the year if an enrollment period is available (example: November 15 – December 31 of every year), or under special circumstances by sending a request to FreedomBlue PFFS or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048, 24 hours a day/7 days a

week. Until my disenrollment is effective, I must keep getting healthcare from FreedomBlue PFFS.

### (5) **Medicare Appeal Process:**

I understand that as a member of the Plan, I have the right to appeal the Plan's decision about payment or services if I disagree.

### (6) **Moves from the Service Area:**

FreedomBlue PFFS serves a specific service area. I understand that it is my job to tell the Plan before I move out of the service area. I understand that if I move permanently out of the service area, Medicare requires FreedomBlue PFFS to disenroll me.

### (7) **Care Received Outside the Country:**

I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

### (8) **Release of Information:**

By joining this Plan, I authorize:

- The Centers for Medicare & Medicaid Services (CMS) to give information to the Plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B); and
- Network doctors and clinics, Highmark or any holder of medical or other information to release to CMS, its contractors, including Highmark or its assignee and other plans, information requested as is necessary for treatment, payment, entitlement and administration of benefits under FreedomBlue PFFS and Medicare.
- I also acknowledge that FreedomBlue PFFS 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.

### (9) **Benefits and Other Plan Information:**

I agree to read the FreedomBlue PFFS Evidence of Coverage that I will receive and follow the written rules for the benefits, copayments, deductibles, coinsurance, exclusions and limitations and other terms as described. I understand that the FreedomBlue PFFS marketing materials, such as the Summary of Benefits, present only highlights of plans and options, and not details. I also understand

that I have the right to review the FreedomBlue PFFS Evidence of Coverage prior to enrollment in FreedomBlue PFFS.

**(10) Third Party Coverage:**

It is my job to tell FreedomBlue PFFS about other prescription drug coverage or expected reimbursement (also called “third party coverage”) for prescription drugs that I have or may get in the future. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me if this plan has Medicare drug coverage.

**(11) Late Enrollment Penalty:**

I understand that if I do not 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 FreedomBlue PFFS determines that I owe a late enrollment penalty, I will need to let FreedomBlue PFFS know if I prefer to pay by mail or Electronic Funds Transfer (EFT) each month.

**People with Limited Incomes:**

You may qualify for extra help to pay for your prescription drug costs. If eligible, Medicare could pay for 75% or more of 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](http://www.socialsecurity.gov/prescriptionhelp).

**Personal Health Information:**

I acknowledge and agree that any personally identifiable health information about me (“Protected Health Information”) 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 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’s Notice of Privacy Practices is available on Highmark’s Web site, or from the Highmark Privacy Office.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially

false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn’t required to agree to accept our plan’s terms and conditions, and thus may choose not to treat you except in emergencies. You should verify that your provider(s) will accept FreedomBlue PFFS before each visit. Providers can find the plan’s terms and conditions on our website at: [www.highmarkblueshield.com](http://www.highmarkblueshield.com).**

Once FreedomBlue PFFS has received your enrollment form, you will receive a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intention to enroll in FreedomBlue PFFS. If FreedomBlue PFFS is not able to reach you by telephone, then you will receive a letter by mail that contains similar information.

As a Medicare Private Fee-For-Service plan, FreedomBlue PFFS works differently than a Medicare Supplement plan as well as other Medicare Advantage plans. FreedomBlue PFFS pays instead of Medicare, and I will be responsible for the amounts that FreedomBlue PFFS does not cover, such as copayments and coinsurances. Original Medicare will not pay for my health care while I am enrolled in FreedomBlue PFFS.

Before seeing a provider, I should verify that the provider will accept FreedomBlue PFFS. I understand that my healthcare providers have the right to choose whether to accept a Private Fee-For-Service plan’s payment terms and conditions every time I see them. I understand that if my provider decides not to accept FreedomBlue PFFS, I will need to find another provider that will.

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with FreedomBlue PFFS, he/she may be compensated based on my enrollment in FreedomBlue PFFS.

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