MEDICARE ADVANTAGE GROUP ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another language or format (Braille), please call 1-855-215-9239 (TTY 711).

Monday – Friday, 8 a.m. to 4:30 p.m.

Mailing Address: P.O. Box 15013, Albany, NY 12212 • Physical Address: 40 Century Hill Drive • Latham, NY 12110

PART 1 PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN

Employer or Union Name CASHIC - Schalmont CSD Medicare **Location** _____

Member plan selection:

☐ 10728345 Forever Blue 799 (PPO) Plan CF12 ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

Effective Date _____ **Member bill level selection:** ☐ **Group bill** ☐ **Member bill**

PART 2 PLEASE TELL US ABOUT YOURSELF

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Email Address _____

PERMANENT RESIDENCE STREET ADDRESS: **(Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)**

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____
area code area code

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 3 MEDICAL ELIGIBILITY INFORMATION

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your 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

_____

Entitled to:

Hospital (Part A) Effective Date _____ / _____ / _____

Medical (Part B) Effective Date _____ / _____ / _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

EGHP_25_8731_C ENR-476 (8-25)

PART 4 **PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY**

Doctor's Last Name _____ First Name _____

Current Patient? ☐ Yes ☐ No

PART 5 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. **Are you the retiree?** ☐ Yes ☐ No

   If YES, retirement date (MM/DD/YYYY) _____

   If NO, name of retiree _____

2. **Are you the spouse of the retiree?** ☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer or union plan?** ☐ Yes ☐ No

   If YES, name of spouse _____

   Name of dependents _____

4. **Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Highmark Blue Shield HMO or PPO?** ☐ Yes ☐ No

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

   Name of other coverage _____

   ID# for this coverage _____ Group# for this coverage _____

5. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No

   If YES, please list the institution's name, address, phone number, and date of admission.

   Name _____ Street _____ Suite# _____

   City _____ State _____ ZIP Code _____

   Phone ( )_____ County _____ Date of Admission _____
   area code (MM/DD/YYYY)

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number _____

7. **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?** ☐ Yes ☐ No

   If YES, what kind of insurance do you have? _____

   What is the name of your insurance? _____

8. **Do you or does your spouse work?** ☐ Yes ☐ No

PART 6 **PLEASE READ AND SIGN ON PAGE 4**

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

Highmark Blue Shield HMO or PPO are Medicare Advantage Plans and have a contract with the Federal government. I will need to keep my Medicare Parts A and 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. 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. 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 if an enrollment period is available (example: annual enrollment period from October 15 – December 7), or under certain special circumstances.

Highmark Blue Shield HMO or PPO serve a specific service area. If I move out of the area that Highmark Blue Shield HMO or PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Highmark Blue Shield HMO or PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Highmark Blue Shield HMO or PPO once I receive 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, beginning on the date Highmark Blue Shield HMO or PPO coverage begins, I must get all of my health care from Highmark Blue Shield, except for emergency or urgently needed services or out-of-area dialysis services. I understand that, beginning on the date Highmark Blue Shield HMO or 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, Highmark Blue Shield HMO or PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by Highmark Blue Shield and other services contained in my Highmark Blue Shield HMO and PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HIGHMARK BLUE SHIELD 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 Highmark Blue Shield, the employee may be paid based on my enrollment in Highmark Blue Shield HMO or PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Shield will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Shield will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 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.

PART 6 **ENROLLEE AUTHORIZATION — SIGNATURE**

Enrollee Authorization

_____ _____

Signature **Today's Date**

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

Last Name _____ First Name _____ Middle Initial _____

Street/Apartment# _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Relationship to Enrollee _____
area code

Please include a copy of your Power of Attorney paperwork.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

☐ I would like to receive my materials in a language other than English

☐ I would like to receive my materials in an accessible format (Braille, Large Print, Data CD, Audio CD, etc.)

Please contact Highmark at 1-800-329-2792 if you need information in an accessible format or language other than English. TTY users should call 711. Our office hours are:

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 5 p.m., Monday – Friday**

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

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Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili.

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이