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# BCN Advantage<sup>SM</sup> HMO-POS Individual Enrollment Form



Confidence comes with every card.®



# BCN Advantage HMO-POS 2020 Individual Enrollment Form

BCN Advantage<sup>SM</sup> HMO-POS



Blue Care  
Network  
of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

We're here to help.

- Need help completing your application?
- Want more information?
- Have questions?
- Interested in finding an independent agent licensed to sell Blue Cross?

Please call us at **1-888-563-3307**. Our hours are 8 a.m. to 9 p.m., Eastern, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users call **711**.

## Ready to enroll in BCN Advantage HMO-POS?

Enroll online by visiting: [www.bcbsm.com/medicare](http://www.bcbsm.com/medicare) or The Centers for Medicare and Medicaid Services Online Enrollment Center at [www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan).

## OR

Enroll using this form. Here are some helpful hints:

- Use a black or blue ink pen.
- Complete a separate form for each person enrolling.
- If you need another copy, make a photocopy or call us.
- Print your answers, except where your signature is required; that's on page 8.
- Make sure you complete each section of the application.
- Mail your application promptly.

Find the region on the County Chart that lists the county in which you permanently live.

Section 1 Find your region and choose only one plan option.

Section 2 Copy the information from your Medicare card onto the picture on the form.

Section 3 Choose just one statement that best applies to you.

Section 4 Choose how to pay your premium.

Sections 5 & 6 Read these carefully and sign after completing Section 6.

**Please do not send your payment** with this application. Return the completed form in the postage-paid envelope, or mail it to:

**BCN Advantage HMO-POS**  
**Mail Code C300**  
**P.O. Box 5013**  
**Southfield, MI 48086-9719**

## What happens next?

- We'll call to make sure you know how this plan works and that you want to enroll. If we can't reach you by telephone, we'll send a letter that explains this.
- Once CMS approves your application, we'll send you a letter within 10 days, confirming your enrollment.
- We'll bill you based on your plan choice (or automatically deduct your premium if you choose that option).
- You'll also receive an information packet about your benefits and the extras you get with your BCN Advantage coverage.

Continued ►

## County Chart

### Monthly premiums vary. To determine your premium:

1. Locate the county in which you permanently live.
2. Find the region your county is in.
3. You'll find the premium list below. It's listed by region.
4. Check only one plan on the application.

County	Region	County	Region	County	Region
Alcona	3	Ingham	2	Muskegon	1
Allegan	1	Ionia	1	Newaygo	1
Alpena	3	Iosco	3	Oakland	5
Antrim	4	Isabella	4	Oceana	1
Arenac	3	Jackson	2	Ogemaw	3
Barry	1	Kalamazoo	1	Osceola	4
Bay	3	Kalkaska	3	Oscoda	3
Benzie	4	Kent	1	Otsego	4
Berrien	2	Lake	4	Ottawa	1
Branch	2	Lapeer	4	Presque Isle	3
Calhoun	2	Leelanau	4	Roscommon	3
Charlevoix	3	Lenawee	4	Saginaw	3
Cheboygan	3	Livingston	4	Sanilac	3
Clare	3	Luce	3	Schoolcraft	3
Clinton	4	Mackinac	3	Shiawassee	3
Crawford	3	Macomb	5	St. Clair	4
Eaton	2	Manistee	4	St. Joseph	2
Emmet	4	Mason	1	Tuscola	3
Genesee	4	Mecosta	4	Van Buren	2
Gladwin	3	Midland	4	Washtenaw	5
Grand Traverse	4	Missaukee	4	Wayne	5
Gratiot	2	Monroe	2	Wexford	4
Hillsdale	2	Montcalm	2		
Huron	3	Montmorency	3		

Please contact BCN Advantage HMO-POS at **1-888-563-3307** if you need information in an accessible format or to be referred to our foreign language line. Call center hours are 8 a.m. to 9 p.m., Eastern, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users call **711**.

1

Complete the following information to enroll in BCN Advantage HMO-POS.

Check which plan you want to enroll in. Choose only one plan. Please use the County Chart when completing this section.

Region (See County Chart)	Elements	Basic	Classic	Prestige
Region 1	<input type="checkbox"/> \$8	<input type="checkbox"/> \$0	<input type="checkbox"/> \$79.30	<input type="checkbox"/> \$181
Region 2	<input type="checkbox"/> \$23.20	<input type="checkbox"/> \$0	<input type="checkbox"/> \$111.30	<input type="checkbox"/> \$263
Region 3	<input type="checkbox"/> \$33.80	<input type="checkbox"/> \$0	<input type="checkbox"/> \$123.30	<input type="checkbox"/> \$241
Region 4	<input type="checkbox"/> \$25	<input type="checkbox"/> \$0	<input type="checkbox"/> \$103.30	<input type="checkbox"/> \$226
Region 5	<input type="checkbox"/> \$30	<input type="checkbox"/> \$0	<input type="checkbox"/> \$128.30	<input type="checkbox"/> \$263

To add an Optional Supplemental Dental, Vision and Hearing package to your plan, check one box below:

☐ Package 1: \$21.40                      ☐ Package 2: \$32.40

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		First name	Middle initial	Last name	
Birth date / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime phone number ( )		Alternate phone number ( )	
Permanent residence street address (No P.O. Box)			City		State
ZIP code		County	Email address (optional)		

Mailing address (only if different from your permanent residence street address)

Street address			
City		State	ZIP code

Optional information

Emergency contact name	
Relationship to you	Phone number ( )

## 2

### Please provide your Medicare insurance 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: \_\_\_\_\_

Is entitled to: \_\_\_\_\_ Effective date: \_\_\_\_\_

HOSPITAL (Part A) \_\_\_\_\_

MEDICAL (Part B) \_\_\_\_\_

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

## 3

### Please read the following statements and check the box that applies to you.

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the open enrollment period from January 1 through March 31 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later find that this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the annual enrollment period (between October 15 and December 7).
- ☐ I am new to Medicare (effective date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently was released from incarceration. I was released on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums), or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

Continued 

- ☐ I am moving into, live in or recently moved out of a Long-term Care Facility (for example, a nursing home or rehabilitation facility). I moved/will move into/out of the facility on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently left a PACE® program on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I am leaving/losing employer or union coverage on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_).
- ☐ I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact BCN Advantage at **1-888-563-3307** to see if you are eligible to enroll. We are open 8 a.m. to 9 p.m., Eastern, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users call **711**.

## 4 Paying your plan premium.

You can pay your monthly plan premium (including any late enrollment fee that you may owe) by mail, electronic funds transfer or an automatic withdrawal from your bank account. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you're assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you'll be notified by the Social Security Administration. You'll be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **Do not** pay the Part D-IRMAA to BCN Advantage HMO-POS.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, 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 a 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)**.

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'll bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you'll get a bill each month. You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check. If you select a BCN Advantage plan with a monthly premium over the Social Security limit, the premium can't be taken out of your Social Security check. Instead, you must pay your premium directly to us. We encourage you to enroll in our electronic funds transfer so you don't have to receive a monthly statement or write a check. Choose automatic deductions if you don't want to get a statement each month.

**Please select a premium payment option:**

- ☐ Electronic funds transfer from your bank account each month. Please allow three to four weeks to process your application. **Please pay any premium bill you may receive while your application is processing.** Future monthly premiums will be automatically withdrawn from your specified account on the **fifth** of every month.

Please enclose a VOIDED check:

Account holder name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_  
(first set of numbers located on left side of check)

Bank account number: \_\_\_\_\_  
(second set of numbers located in the center of check)

Account type:    ☐ Checking        ☐ Savings

- ☐ Get a bill on a monthly basis. You may choose from the following payment methods:

**Pay online:** To learn how to pay your premium online, go to **www.bcbsm.com/ebilling**.

**Pay by phone:** Call BCN Advantage Customer Service at **1-800-450-3680**, 8 a.m. to 8 p.m., Eastern, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users call **711**.

**Pay by mail:** Mail your check, cashier's check or money order made payable to Blue Care Network directly to **Blue Care Network, P.O. Box 33608, Detroit, MI 48232-5608**.

- ☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from:    ☐ Social Security        ☐ RRB

The Social Security/Railroad Retirement Board deduction may take two or more months to begin after Social Security or the RRB approves the deduction. Please pay any premium bills prior to your Social Security/Railroad Retirement Board deduction effective date. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board doesn't approve your request for automatic deduction, we'll send you a paper bill for your monthly premiums.

# 5

## Please read and answer these important questions.

1. Please choose a Primary Care Physician (PCP). Please note that not all Blue Care Network providers are contracted with BCN Advantage. Please verify that your PCP is contracted with BCN Advantage.

Name of PCP: \_\_\_\_\_ City: \_\_\_\_\_

Are you a current patient of this doctor?    ☐ Yes    ☐ No

2. Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have additional medical or prescription drug coverage in addition to BCN Advantage HMO-POS?

☐ 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: \_\_\_\_\_

Continued 



3. 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	
City	State	ZIP code	Phone number

4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

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 for additional information.

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

If "yes," please provide your Medicaid number: \_\_\_\_\_

6. Do you or your spouse work? ☐ Yes ☐ No

Please contact BCN Advantage HMO-POS at **1-888-563-3307** with questions, if you need information in an accessible format or to be referred to our foreign language line. Call center hours are 8 a.m. to 9 p.m., Eastern, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users call **711**.



## 6

### Please read this important information.

If you currently have health coverage from an employer or union, joining BCN Advantage HMO-POS could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCN Advantage HMO-POS. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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

- BCN Advantage HMO-POS is a Medicare Advantage plan and has a contract with the federal government. I 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 or prescription drug plan. It's my responsibility to tell you about 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 when an enrollment period is available, generally during the annual enrollment period (October 15 – December 7) or open enrollment period (January 1 - March 31), unless I qualify for certain special circumstances.

- BCN Advantage HMO-POS serves a specific area. If I move out of the area that BCN Advantage HMO-POS 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 BCN Advantage HMO-POS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document (also known as a member contract or subscriber agreement) from BCN Advantage HMO-POS 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 beginning on the date BCN Advantage HMO-POS coverage begins, I must get all of my health care from BCN Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCN Advantage HMO-POS and other services contained in my BCN Advantage HMO-POS *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BCN ADVANTAGE HMO-POS WILL PAY FOR THE SERVICES.
- I understand that if I get help from a sales agent, broker or other individual employed by or contracted with BCN Advantage HMO-POS, he/she may be paid based on my enrollment in BCN Advantage HMO-POS.

### Release of Information:

By joining this Medicare health plan, I acknowledge that BCN Advantage HMO-POS will release my information to Medicare and other plans as needed for treatment, payment and health care operations. I also acknowledge that BCN Advantage HMO-POS will release my information including my prescription drug data to Medicare, which may release it for research or 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 content 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	Date / /
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If you are the authorized representative of the enrollee, you must sign above and provide the following information:

Name		Phone ( )	
Street address	City	State	ZIP code
Relationship to applicant			

## AGENT/OFFICE USE ONLY (Applicants do not complete this section)

**Note to producing agents:** Paper enrollment forms must be keyed into [www.bcbsm.com/accessmedicare](http://www.bcbsm.com/accessmedicare) or submitted to the managing or general agent within 24 hours of accepting the paper enrollment form.

Date producing agent accepted paper enrollment from Medicare eligible:  /  /

Date managing or general agent or association received paper enrollment form from producing agent:  /  /

Name of managing/general agent or association: \_\_\_\_\_

Name of producing agent (print first/last names): \_\_\_\_\_  
First name Last name

Signature of producing agent: \_\_\_\_\_

Email of producing agent: \_\_\_\_\_

2-digit managing or general agent or association code:

5-digit producing agent code:

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant: ☐ Yes ☐ No

Name of person entering enrollment information online (print first/last names): \_\_\_\_\_  
First name Last name

Please note: Not all BCN providers are contracted with BCN Advantage. Please verify that the primary care physician listed in this form is contracted with BCN Advantage by calling **1-888-563-3307**. TTY users call **711**.

Be sure to have the member complete Sections 3 and 5 in their entirety. Return this form to:

BCN Advantage HMO-POS  
Mail Code C300  
P.O. Box 5013  
Southfield, MI 48086-9719

***BCN Advantage<sup>SM</sup> HMO-POS***



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**[www.bcbsm.com/medicare](http://www.bcbsm.com/medicare)**