FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please fax or email this cover letter with the completed application to:

FAX#: (847) 220-9280 or email a scanned copy to help@ilhealthagents.com

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

- ❑ Please contact me at this phone number after you have reviewed my application for completeness and accuracy _____.
- ❑ Please contact me at this email after you have reviewed my application for completeness and accuracy _____.

BlueCross BlueShield of Illinois

Blue Cross MedicareRx℠ Medicare Prescription Drug Plan Individual Enrollment Form

Please contact Blue Cross MedicareRx if you need information in another language or format (Braille).

To enroll in Blue Cross MedicareRx, please provide the following information:

Please check the plan you want to enroll in:

☐ **Blue Cross MedicareRx Basic (PDP)℠** $26.10 per month	☐ **Blue Cross MedicareRx Value (PDP)℠** $65.50 per month	☐ **Blue Cross MedicareRx Plus (PDP)℠** $163.70 per month

LAST name:	FIRST name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ☐☐ ☐☐ ☐☐☐☐ (MM / DD / YYYY)	Sex: ☐ M ☐ F		Home Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency Contact:

Phone Number: Relationship to You:

Email Address:

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.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: SAMPLE ONLY

Medicare Claim Number Sex ____

— — — - — — - — — — — ____

is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Applicant LAST name: FIRST name:

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment 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 determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.	
☐ 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	
☐ I get Extra Help paying for Medicare prescription drug coverage.	
☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on (insert date).	/ /
☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or long term care 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 (as good as Medicare's). I lost my drug coverage on (insert date).	/ /
☐ I am leaving 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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date).	/ /

If none of these statements applies to you or you're not sure, please contact Blue Cross MedicareRx at 1-888-285-2249 to see if you are eligible to enroll. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. TTY/TDD users should call 711.

Applicant LAST name:	FIRST name:

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 the Part D-IRMAA extra amount to Blue Cross MedicareRx.

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 coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about 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.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name:

Bank routing number: _ _ _ _ _ _ _ _ _

Bank account number: _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. 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 does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Applicant LAST name: FIRST name:

Please answer the following questions:

1. Are you an existing Blue Cross and Blue Shield of Illinois Medicare member who is changing plans?
☐ Yes ☐ No

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Do you have existing prescription drug coverage? ☐ Yes ☐ No

Name of existing coverage: _____

Will you have other **prescription** drug coverage in addition to Blue Cross MedicareRx? ☐ 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: _____

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 & Phone Number of Institution (number and street):

_____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

☐ Spanish

☐ Braille/Large Print

Please contact Blue Cross MedicareRx at 1-888-285-2249 if you need information in another format or language than what is listed above. TTY/TDD users should call 711. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Please Read this Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Blue Cross MedicareRx, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Blue Cross MedicareRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross MedicareRx. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Applicant LAST name: FIRST name:

Please Read and Sign Below:

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

Blue Cross MedicareRx is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Cross MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time — if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Cross MedicareRx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Blue Cross MedicareRx serves a specific service area. If I move out of the area that Blue Cross MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue Cross MedicareRx network pharmacies. Once I am a member of Blue Cross MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross MedicareRx when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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

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

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and Blue Cross and Blue Shield of Illinois (BCBSIL), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSIL to use the Blue Cross and/or Blue Shield Service Marks in the State of Illinois, and that BCBSIL is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSIL and that no person, entity, or organization other than BCBSIL shall be held accountable or liable to Subscriber for any of BCBSIL's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSIL other than those obligations created under other provisions of this agreement.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Blue Cross MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross MedicareRx 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law 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 Medicare.

Applicant LAST name:	FIRST name:

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: Name:	
Address:	
Phone Number: ( )	
Relationship to Enrollee:	

Medicare Prescription Drug Plan Use Only:				
Plan ID #:				
Effective Date of Coverage:	Date: ☐☐/☐☐/☐☐	IEP: _____	AEP: _____	SEP (type): _____

Applicant LAST name:	FIRST name:

Agent Information

To receive your compensation, you must complete the following information, and the enrollee must meet certain requirements (see information to right). If you do not complete this section of the form, you will not be paid for this enrollee.

As the producer, I attest that the following information is true. By signing this enrollment form, I understand that providing false information can lead to disciplinary action up to and including loss of compensation payments and/or termination of the Blue Cross MedicareRx amendment.

Requirements for compensation payments:

- Be licensed and, where applicable, appointed;
- Successfully completed the 2017 Blue Cross MedicareRx training and certification program prior to marketing, selling, signing any enrollment form or conducting service for Blue Cross MedicareRx; and
- Enrolled a member who has been approved by CMS, and has not canceled prior to becoming effective.

	Yes	No
I fulfilled the CMS annual training requirement by completing the 2017 AHIP and Blue Cross MedicareRx training and certification program requirements and did so before marketing, selling or conducting service with this enrollee.	☒	☐
Method of Scope	**Yes**	**No**
I conducted a personal face-to-face marketing appointment with this applicant, as a result, I have a signed Scope of Appointment and understand that I may be asked to provide this documentation as part of the Blue Cross MedicareRx Monitoring & Oversight Program.	☐	☐
Please indicate the method by which this applicant's Scope of Appointment (SOA) was completed (Please check one): ☐ Paper ☐ Electronic ☐ Telephone ☐ Seminar attendee (No SOA required)	**N/A**	
	Yes	**No**
I provided the enrollee with information about eligibility requirements, enrollment periods, lock-in provisions, benefits, premiums, use of network pharmacies, billing options and the availability of Extra Help prior to his or her completing this enrollment form.	☐	☐

Please enter the following information carefully and legibly. Accurate and timely compensation payments depend on this information.

Writing Agent ID# (This is your BCBSIL assigned ID#): 0 0 0 6 2 8 1 3 8 (Not SSN or TID)	Phone Number: 312-588-9915	
First Name: Ryan	Middle Initial:	Last Name: Kennelly
Producer Signature: **X**		Date: ☐☐/☐☐/☐☐

Applicant LAST name: FIRST name:

Electronic Application ID

☐☐☐☐☐☐☐☐☐☐

The [Formulary, pharmacy network, and/or provider network] may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call our Customer Service number at 1-888-285-2249 (TTY/TDD users should call 711). We are open between 8:00 a.m. and 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Esta información está disponible en otros idiomas de forma gratuita. Comuníquese a nuestro número de Servicio al cliente al 1-888-285-2249 (los usuarios de TTY/TDD deben llamar al 711). Nuestro horario es de 8:00 a.m. a 8:00 p.m., hora local, los 7 días de la semana. Si usted llama del 15 de febrero al 30 de septiembre, durante los fines de semana y feriados, se usarán tecnologías alternas (por ejemplo, correo de voz).

You must continue to pay your Medicare Part B premium.

Prescription drug plan provided by Blue Cross and Blue Shield of Illinois, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.