2025 Medicare Blue Choice® (HMO-POS) and Medicare Blue® PPO Employer/Union Group Health Plan Enrollment Request Form

Excellus

Excellus BlueCross BlueShield
Attn: Enrollment Operations
PO Box 31790
Rochester, NY 14603-1790

B-3687Y25 - Rochester Group

Y0028_10309_C

Please contact Excellus BlueCross BlueShield if you need information in another language or format (Braille).

For Internal Use

To Enroll in Excellus BlueCross BlueShield, Please Provide the Following Information:

EMPLOYER OR UNION NAME:

GROUP #:

SUBGROUP/CLASS/ENROLLMENT CODE:

EFFECTIVE DATE (MM/DD/YYYY):

Please check which plan you want to enroll in:

☐ Medicare Blue Choice® (HMO-POS) ☐ Medicare Blue® PPO

LAST NAME:

FIRST NAME:

MIDDLE INITIAL:

BIRTH DATE (MM/DD/YYYY):

SEX:
☐ MALE
☐ FEMALE

HOME PHONE NUMBER: ( )

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY:

COUNTY:

STATE:

ZIP CODE:

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

EMAIL ADDRESS:

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.

Excellus BlueCross BlueShield is an HMO plan and PPO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

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.

Please read and answer these important questions:

1 Are you the retiree? ☐ YES ☐ NO

If yes, retirement date (month/date/year):

If no, name of retiree:

2 Do you or your spouse work? ☐ YES ☐ NO

If yes, please provide name of employer:

3 Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Excellus BlueCross BlueShield? ☐ YES ☐ NO

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

Name of other coverage: ID# for coverage:

4 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):

IMPORTANT: Please read the following

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

Excellus BlueCross BlueShield is a Medicare Advantage plan and has a contract with the Federal Government.

- I will need to keep my Medicare Parts A and B. I can only be in 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.
- Excellus BlueCross BlueShield serves a specific service area. If I move out of the area that Excellus BlueCross BlueShield 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 Excellus BlueCross BlueShield, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the Evidence of Coverage document from Excellus BlueCross BlueShield 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.

IMPORTANT: Read and Sign on the Next Page:

IMPORTANT: Read and Sign Below:

- I understand that beginning on the date Excellus BlueCross BlueShield coverage begins, I must get all of my health care from Excellus BlueCross BlueShield, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Excellus BlueCross BlueShield and other services contained in my Excellus BlueCross BlueShield Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR EXCELLUS BLUECROSS BLUESHIELD 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 Excellus BlueCross BlueShield, he/she may be paid based on my enrollment in Excellus BlueCross BlueShield.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Excellus BlueCross BlueShield 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 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.

SIGNATURE: **TODAY'S DATE:**

If you're the authorized representative, sign above and fill out these fields:

NAME: ADDRESS:

PHONE NUMBER: **RELATIONSHIP TO ENROLLEE:**

( )

Send completed application to:
Excellus BlueCross BlueShield, Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603 1790

Office Use Only: **Plan ID#:** _____

Effective Date of Coverage: _____

ICEP / IEP: _____ AEP / MA OEP: _____ SEP (type): _____

Name of staff member/agent/broker (if assisted in enrollment): _____ Not Eligible: _____

Agent/Broker Signature: _____ **NPN: #**_____ **Date Received:** _____

All fields in this section are optional

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term:_____
- ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer.**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP): _____

Email Address: _____