Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield
MedAdvantage (PPO) Enrollment Request Form

Please include ALL pages of the enrollment form when submitting

●PLEASE PRINT IN INK●

Please provide the following information:	
Employer or Trust Name: **Association of Washington Cities Retirees - LEOFF 1**	
Please check which plan you want to enroll in: ☐ AWC LEOFF1 MedAdvantage + Rx Enhanced Plus Opt 1 (PPO)	**Requested Effective Date:** _____ — _____ — _____ MM DD YYYY

LAST Name	FIRST Name	Middle Initital	☐ Mr. ☐ Mrs. ☐ Ms.
Birthdate: (mm/dd/yyyy)	Sex: ☐ M ☐ F	Home Phone Number	Medicare Number (Required)
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:	
Your e-mail address:			

By providing your email, you give permission to be contacted about future Medicare news and plan information via email. You may opt out of email communication at any time.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 be billed directly by Medicare or the Railroad Retirement Board. DO NOT pay Regence MedAdvantage the Part D-IRMAA.

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 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 this extra help, contact your 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. **You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month or by having it deducted from your bank account.**

Please read and answer these important questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Regence MedAdvantage?

Yes ☐ No ☐

If "yes", please list your other coverage:

Name of other coverage _____

ID Number for this coverage _____

Group Number for this coverage _____

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

3. Are you the retiree? ☐ Yes ☐ No

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

If no, name of retiree _____

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):

_____

Please contact Regence MedAdvantage at 1-888-319-8904 (TTY users should call 711) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.

Please choose the name of a Primary Care Physician (PCP), clinic, or health center:

First and Last Name of PCP: _____

PCP Address: _____

PCP Phone Number: _____

Answering these following 2 questions is your choice. You can't be denied coverage because you don't fill them out.

1. 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
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

2. What's your race? Select all that apply.

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

Please read and sign on page 5

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

Regence BlueShield MedAdvantage 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 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 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 when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

Once I am a member of Regence MedAdvantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Regence MedAdvantage when I get it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Regence MedAdvantage 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, Regence MedAdvantage provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Regence MedAdvantage and other services contained in my Regence MedAdvantage Evidence of Coverage document will be covered. Without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE 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 Regence MedAdvantage, he/she may be paid based on my enrollment in Regence MedAdvantage.

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

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 Regence MedAdvantage 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. I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give Medicare or their agents the information needed to run the Medicare program. 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 by Regence MedAdvantage or by Medicare.

Your Signature*: ▶_____ Date: _____
month/day/year

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

Name: _____ Relationship to enrollee: _____

Address: _____ Phone Number: _____

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Regence MedAdvantage is a PPO with a Medicare contract. Enrollment in Regence MedAdvantage depends on contract renewal.