OFFICE USE ONLY		
Date Received:	Rep Code:	Group Number:
Check Number:	Check Amount:	Effective Date:

HIGHMARK. SECURITYBLUE℠

A Medicare Advantage HMO
from Keystone Health Plan West

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

Image ID #

ENROLLMENT APPLICATION

If you have questions when filling out this application, call 1-800-576-6343 (TTY: 1-800-862-0709)

(1) Information About You (Please fill in your name *exactly* as it appears on your Medicare card.)

First Name	Middle Initial (if applicable)	Last Name	Suffix	Home Phone (with area code) ( )

Home Address (No P.O. Boxes)	Apt#	City	State	Zip	County

Mailing Address (P.O Boxes allowed)	Apt#	City	State	Zip	Spouse's Name (if applicable)

Social Security Number *(optional)*	Date of Birth	Sex	Spouse's Social Security Number (if applicable)
– –	/ /	☐ Male ☐ Female	– –

Person To Contact In An Emergency	Emergency Contact Phone Number (with area code) ( )

(2) Medicare Information

Please fill in your claim number and effective dates ***exactly*** as they appear on your Medicare Card, or attach a copy of your Medicare Card, or your confirmation letter of Medicare eligibility.

Medicare Health Insurance

SOCIAL SECURITY ACT

Claim Number

_____

Is Entitled To	Effective Date
Hospital Part A	__ __-__-__ __
Medical Part B	__ __-__-__ __

You must have Medicare Parts A and B to enroll.

(3) Plan Selection (Check One)

☐ **Value**
☐ **Standard**
☐ **Deluxe**

☐ **CARE**
For people with Medicare and Medicaid only

(4) Plan Premium Payment Option

You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, the plan will send you a bill quarterly which you can pay by mail or Electronic Funds Transfer (EFT). Generally, you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some of your plan premium. Please choose if you want remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? Yes ☐ No ☐

(5) Other Insurance

1. Are you currently enrolled in KeystoneBlue? Yes ☐ No ☐

2. Will either you or your spouse be employed once enrolled in SecurityBlue? Self: Yes ☐ No ☐ Spouse: Yes ☐ No ☐
   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____

3. Will you have any Health Insurance other than SecurityBlue or Medicare that will continue after your enrollment? Yes ☐ No ☐
   (If NO is selected, please skip to Section 6 of the application)

Please specify type of insurance:
☐ Active Employer Group Insurance ☐ Retiree Coverage ☐ Supplemental Coverage
☐ Direct Pay Policy ☐ Veteran's Administration Coverage
☐ Federal Black Lung Coverage ☐ Workman's Compensation Coverage

Please specify type of coverage:
☐ Medical Only ☐ Medical with Prescription Drug Coverage
☐ Prescription Drug Coverage Only ☐ Dental or Vision Only

4. Is this insurance provided by: ☐ Your Employer ☐ Your Spouse's Employer ☐ Individual Plan

5. Does your employer have: ☐ 1 - 19 employees ☐ 20 - 99 employees ☐ more than 100 employees
Does your spouse's employer have: ☐ 1 - 19 employees ☐ 20 - 99 employees ☐ more than 100 employees

6. Your employer's name _____ Your insurance name: _____

Your insurance policy # _____ Your insurance group # _____

7. Spouse's employer's name _____ Spouse's insurance name: _____

Spouse's insurance policy # _____ Spouse's insurance group # _____

STOP! If you currently have health care coverage from an employer or union group, contact your benefits administrator about your intentions to enroll in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan may effect your employer or union health benefits.

(6) Primary Care Physician Selection

Name of Primary Care Physician Practice	PCP # (from the SecurityBlue Provider Directory)	Are you currently a patient of this physician? Yes ☐ No ☐

(7) Please Answer The Following Questions

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in SecurityBlue means you will be automatically disenrolled from your current Medicare Advantage plan.)* Yes ☐ No ☐

Do you have End-Stage Renal Disease (A regular course of kidney dialysis or transplant is required to maintain your life)? *(If yes, then you are **not** eligible to enroll UNLESS you are already a KeystoneBlue member.)* Please note: if you had a kidney transplant and no longer need dialysis to maintain your life or enrolled with ESRD in a Medicare Advantage plan that has withdrawn from your coverage area, then you may enroll in SecurityBlue. **Please attach a note or records from your doctor if you no longer need dialysis or have had a successful kidney transplant.** Yes ☐ No ☐

Are you currently enrolled in PACE (Pharmaceutical Assistance Contract for the Elderly) or PACENET? *(This does not affect your eligibility to enroll.)* Yes ☐ No ☐

Are you currently a Medicaid recipient? *(This does not affect your eligibility to enroll in Value, Standard or Deluxe)* Yes ☐ No ☐

If you answered YES, please provide your Medicaid Number: _____

Are you currently a resident in a Medicare or Medicaid certified institution?
(e.g. Skilled Nursing Facility, Rehabilitation Hospital - - *This does not affect your eligibility to enroll.)* Yes ☐ No ☐

If you answered YES, please provide the following information:

Name of Institution:	Address of Institution (number and street)

Phone number of Institution: ( )	Date you were admitted to the Institution:

(8) Statements Of Understanding And Authorization

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. My signature below warrants that I have read and understand the contents of this application, **including the Statements of Understanding and Authorization and Personal Health Information that appear on the back of this application,** and that the information provided by me is accurate and complete. **Your *signature* is required in order to process this application.**

Your Signature	Date

Also, any person who signs the application for the applicant must attach a copy of the applicant's Power of Attorney or documentation of Legal Guardianship to complete application processing.

POA or Legal Guardian's Signature	POA or Legal Guardian's Name *(please print)*

Please return top copy of this form and keep the pink copy for your records

Statements of Understanding and Authorization

(1) Effective Date:
I understand that SecurityBlue will notify me in writing of my confirmed effective date of enrollment in SecurityBlue. I understand that, generally, my effective date will be the first of the month following the month in which SecurityBlue receives my completed enrollment application. I understand that I may want to consider not cancelling any Medicare supplement plan or Medigap/Medicare Select plan until I am notified in writing of my confirmed effective date in SecurityBlue.

(2) Medicare Eligibility and Medicare Premiums:
I understand that I must be entitled to Medicare Part A and enrolled in Part B to be eligible to join SecurityBlue. I also understand that I must keep my Medicare Part A and Part B insurance by paying the Part B premiums and the Part A premiums, if applicable.

(3) Medicare Advantage Plan Selection:
I understand that I can be a member of only one Medicare Advantage plan at a time. By enrolling in the plan on this form, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member. I also understand that since I can be a member of only one Medicare Advantage plan at one time, I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage. If I do this, my enrollments will be cancelled and I will have to fill out a new enrollment form to become a member of a Medicare Advantage plan.

(4) Voluntary Disenrollment:
I understand that I may choose to disenroll from SecurityBlue only at certain times of the year by sending a written request to the Plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (TTY: 1-877-486-2048). Until my disenrollment is effective, I must keep getting health care from SecurityBlue doctors and other network providers.

(5) Medicare Appeal Process:
I understand that as a member of the Plan, I have the right to ask about the Plan's decision about payment or services if I disagree.

(6) Moves from the Service Area:
I understand that it is my job to tell the Plan before I move out of the service area. I understand that if I move permanently out of the service area, Medicare requires SecurityBlue to disenroll me.

(7) Primary Care Doctor Selection:
I understand that I should have my SecurityBlue Primary Care Physician (PCP) designated in Section (6) of this Enrollment Application. Failure to select a SecurityBlue PCP will not delay my enrollment. I also understand that if I do not select a SecurityBlue PCP and SecurityBlue is unable to contact me to select a PCP, one will be selected for me by SecurityBlue. I will receive an identification card indicating the name and number of my PCP once I become a member of SecurityBlue. I can contact SecurityBlue when I receive this identification card and change to a different PCP if I do not wish to remain with the PCP that SecurityBlue selected for me.

(8) Lock-in and Coordinated Care:
I understand that, beginning on the date my Medicare Advantage plan coverage begins, I must get all of my health care, including durable medical equipment, from SecurityBlue network providers. The only exceptions to this are when I seek emergency, urgently needed care and out-of-area renal dialysis services. I understand that SecurityBlue recommends that my chosen PCP coordinate all the medical services that I need. I understand that without authorization, NEITHER MEDICARE NOR SECURITYBLUE WILL PAY FOR THE SERVICES. I also understand that I am free to see any SecurityBlue network provider without a referral. Certain services still require authorization. I understand that if I see another network PCP other than my selected PCP, I will incur a specialist copayment for the visit.

(9) Release of Information:

By joining this Plan, I authorize:

- The Centers for Medicare & Medicaid Services (CMS) to give information to the Plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B); and
- Network doctors and clinics, Keystone Health Plan West or any holder of medical or other information to release to CMS, its contractors, including Keystone Health Plan West or its assignee, any information requested with respect to entitlement and administration of benefits under SecurityBlue and Medicare.

(10) Benefits and Other Plan Information:

I agree to follow the written rules for the benefits, copayments, exclusions and limitations and other terms as described in the SecurityBlue Evidence of Coverage that I will receive. I understand that the SecurityBlue marketing materials, such as the Summary of Benefits, present only highlights of plans and options, and not details. I also understand that I have the right to review the SecurityBlue Evidence of Coverage prior to enrollment in SecurityBlue.

(11) Third Party Coverage:

It is my job to tell SecurityBlue about other prescription drug coverage or expected reimbursement (also called "third party coverage") for prescription drugs. If I intentionally misrepresent this information, Medicare requires the plan to disenroll me if this plan has Medicare drug coverage.

(12) Coverage from an Employer or Union Group:

If I currently have health coverage from an employer or union group, enrolling in other coverage could affect my employer or union benefits. I should discuss my decision to enroll in a Medicare plan with my benefits administrator.

Personal Health Information:

I acknowledge and agree that any personally identifiable health information about me ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Please return the top copy of this form and keep the pink copy for your records.

SecurityBlue
c/o PNC Bank
P.O. Box 1085
Pittsburgh, PA 15230-9555