Enrolling is Simple.
Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 877-566-5454 fax: 760-433-0304

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Barricks Insurance Services

276 N El Camino Real #6

Oceanside, CA 92058

Please make your check payable to: Blue Shield of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 877-566-5454

Thank you for choosing...

blue of california

2017 Individual Enrollment Request Form

Blue Shield 65 Plus (HMO) and Blue Shield 65 Plus Choice Plan (HMO)

Please contact Blue Shield of California if you need information in another language or format (large print).

Please fax or mail your completed enrollment form to:

Fax: (877) 251-3660

Mail: Blue Shield of California
P.O. Box 948, Woodland Hills, CA 91365-9856

To enroll in Blue Shield 65 Plus℠ or Blue Shield 65 Plus Choice Plan, please provide the following information:

Please check which plan you want to enroll in, based on where you live:

- ☐ Los Angeles*/Orange counties ($0 per month)
- ☐ Los Angeles*/Orange counties – **Choice Plan** ($0 per month)
- ☐ Fresno County ($0 per month)
- ☐ Riverside* County ($0 per month)
- ☐ Sacramento* County ($29 per month)
- ☐ San Bernardino* County ($0 per month)
- ☐ San Diego County ($0 per month)
- ☐ Ventura* County ($0 per month)

*See your Summary of Benefits for covered ZIP codes.

Please indicate if you would like to enroll in the Optional Supplemental Dental HMO or PPO plan

☐ Optional Supplemental Dental HMO plan ($12.90 per month)
Name of dentist _____ Provider ID# _____
If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

☐ Optional Supplemental Dental PPO plan ($33.40 per month)
No dentist selection necessary for the PPO plan.

☐ Mr. ☐ Mrs. ☐ Ms.	Last name	First name	Middle initial

Birth date (__ __/__ __/__ __ __ __) (MM/DD/YYYY)	Sex ☐ M ☐ F	Home phone number ( )

Permanent residence street address (P.O. Box is not allowed)

Street	City	State	ZIP code

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

Street	City	State	ZIP code

Email address

☐ I am willing to receive required plan materials via email (i.e., enrollment notifications, the Annual Notice of Changes and *Evidence of Coverage*, and plan newsletter) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via mail. You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

Jim Barricks
Barricks Insurance Services
Agent #063287258

Please provide your Medicare insurance information

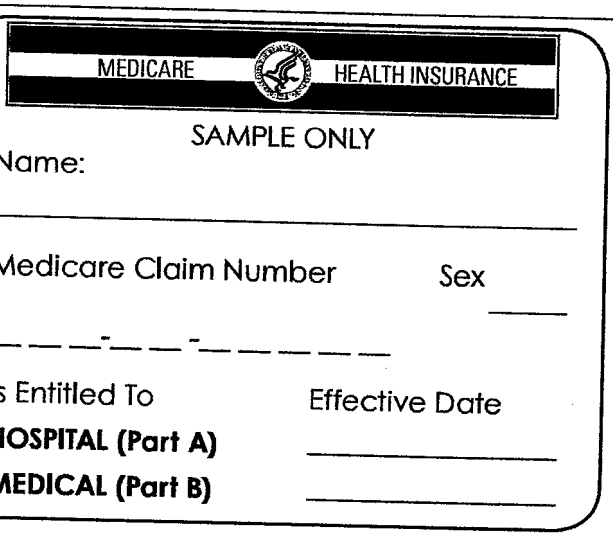
Please take out your Medicare card to complete this section.

- 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 and Part B to join a Medicare Advantage Plan.



Paying your plan premium

You can pay your monthly plan premium, if you have one (including any late enrollment penalty that you currently have or may owe, and the Optional Supplemental Dental HMO or PPO plan premium, if you enrolled in that plan), by mail or by "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 (RRB) 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 benefit check or be billed directly by Medicare or the RRB. DO NOT pay Blue Shield of California the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. 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**.

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 get a bill each month.

Please select a premium payment option:

☐ Get a monthly 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 or Railroad Retirement Board (RRB) benefit check. (The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions

1. 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 anymore, **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 to obtain additional information.

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

Will you have other prescription drug coverage in addition to Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan? ☐ Yes ☐ No

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

Prescription drug coverage

Name of other coverage	ID No. for this coverage	Group No.
_____	_____	_____

Medical coverage

Name of other coverage	ID No. for this coverage	Group No.
_____	_____	_____

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 and phone number of institution (number and street) _____

_____

4. Are you enrolled in your state Medicaid program (Medi-Cal)? ☐ Yes ☐ No

If "yes," please provide your Medicaid (Medi-Cal) number

_____

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

Choose a primary care physician and physician group

Physician name _____

Physician ID No. _____ Current patient ☐ Yes ☐ No

Physician group name _____

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 ☐ Large print

Please contact Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan at **(800) 776-4466** [TTY **711**] if you need information in a format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through February 14, and 8 a.m. to 8 p.m., weekdays, from February 15 through September 30.

Please read this important information

If you currently have health coverage from an employer or union, joining Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan. 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.

Please read and sign below

By completing this enrollment application, I agree to the following: Blue Shield 65 Plus and Blue Shield 65 Plus Choice Plan are Medicare Advantage Plans and have 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 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. 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 through December 7 of every year), or under certain special circumstances.

Blue Shield 65 Plus and Blue Shield 65 Plus Choice Plan serve a specific service area. If I move out of the area that Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan serve, 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 Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan, 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 Shield 65 Plus or Blue Shield 65 Plus Choice Plan 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 Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan coverage begins, I must get all of my health care from Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan and other services contained in my Blue Shield

65 Plus or Blue Shield 65 Plus Choice Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS NOR BLUE SHIELD 65 PLUS CHOICE PLAN 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 Blue Shield of California, he/she may be paid based on my enrollment in Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan.

Release of information: By joining this Medicare health plan, I acknowledge that Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Blue Shield of California 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 are the legally authorized representative (i.e., power of attorney or legal guardian – see description above), you must sign above and provide the following information:

Name _____

Address _____

Phone number (_____) _____ Relationship to enrollee _____

Producer information: Producer name and ID or NPN **is required**

TMO/GMO/Agency name _____
(please print appointed agency name)

TMO/GMO/Agency ID No. _____
(please print agency ID)

Producer name JAMES BARRICKS
(please print writing agent name)

Producer ID No. 063287258
(please print agent ID number or NPN)

Producer phone number (760) 433-0300

Producer email address INSURE@BARRICKSINSURANCE.COM

Date application received by producer _____

Producer signature _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete pre-sale kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Typically, you may enroll in a Medicare Advantage Plan only during the Annual Enrollment Period from October 15 through December 7 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 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 United States. I returned to the United States 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 drugs. I stopped receiving extra help on (insert date) _____.
- ☐ I am moving into, 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 (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 was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact Blue Shield Member Services at **(800) 776-4466** (TTY **711**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week, from October 1 through February 14, and 8 a.m. to 8 p.m., weekdays, from February 15 through September 30.

Office use only:

Name of staff member (if assisted enrollment) _____
(Please print name)

Plan ID No. _____ Effective date of coverage _____ ICEP/IEP _____

AEP _____ SEP (type) _____ Not eligible _____ NIPR No. _____