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 Form

Blue Shield Medicare Basic Plan (PDP) and Blue Shield Medicare Enhanced Plan (PDP)

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 a Blue Shield Medicare Prescription Drug Plan, please provide the following information:

Please check which plan you want to enroll in:

☐ Blue Shield Medicare Basic Plan (PDP) ($82.40 per month)
☐ Blue Shield Medicare Enhanced Plan (PDP) ($129.30 per month)

☐ Mr. ☐ Mrs. ☐ Ms.	Last name	First name	Middle initial
Birth date (M M / D D / Y Y Y Y) (/ /)		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

S2468_16_183A Approved 07122016

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.

SAMPLE ONLY

Name:

_____

Medicare Claim Number Sex

___-___-____ ____

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) 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 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 Shield of California.

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 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 receive a bill each month.

Please select a plan premium payment option:

☐ Receive a monthly statement and pay by mail.

☐ 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. 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 plan 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 answer the following 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 the Blue Shield Medicare Prescription Drug Plan that you are enrolling in?

☐ Yes ☐ No

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

Name of other coverage _____

ID No. for this coverage _____

Group No. for this coverage _____

2. 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) _____

_____

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 of California at **(888) 239-6469** [TTY users should call **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 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 a Blue Shield Medicare Prescription Drug Plan, 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 a Blue Shield Medicare Prescription Drug Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a Blue Shield Medicare Prescription Drug 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 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 Medicare Basic Plan and Blue Shield Medicare Enhanced Plan are Medicare drug plans and have 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 my Blue Shield Medicare Prescription Drug Plan 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 a Blue Shield Medicare Prescription Drug Plan 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 through December 7), unless I qualify for certain special circumstances.

Blue Shield Medicare Prescription Drug Plans serve a specific service area. If I move out of the area that Blue Shield Medicare Prescription Drug Plans serve, 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 Shield Medicare Prescription Drug Plan network pharmacies. Once I am a member of a Blue Shield Medicare Prescription Drug 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 Medicare Basic Plan or Blue Shield Medicare Enhanced Plan 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 Shield of California, he/she may be paid based on my enrollment in

a Blue Shield Medicare Prescription Drug Plan. 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.

Release of information: By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Shield Medicare Basic Plan or Blue Shield Medicare Enhanced Plan will release my information to Medicare or 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 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.

Signature _____ **Today's date** _____

If you are the 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 (for producer use only): 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 (please print writing agent name) JAMES BARRICKS

Producer ID No. (please print agent ID number or NPN) 0632872S8

Producer email address INSURE@BARRICKSINSURANCE.COM

Producer phone number (760) 433-0300

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 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 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 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 Shield Member Services at **(888) 239-6469** 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. TTY users should call **711**.

Medicare Prescription Drug Plan use only:

Plan ID No. _____ Effective date of coverage _____

IEP _____ AEP _____ SEP (type) _____

Name of plan representative (please print name) _____

NIPR No. _____