Keystone 65 HMO
A Blue Cross Medicare Advantage Plan from Keystone Health Plan East

EMPLOYER GROUP APPLICATION/CHANGE FORM

Please contact Keystone 65 HMO if you need information in another language or format (Braille).

Easy step-by-step instructions for filling out this *Keystone 65 HMO* enrollment form.

SECTION A — **Personal Information —** Provide the personal information requested. Then check the box(es) in front of your requested action and provide information about your employer or union.

SECTION B — **Medicare Insurance Information —** Use your Medicare card to complete this section.

SECTION C — **Important Questions —** Please answer the questions in this section.

SECTION D — **Choose Your Providers —** Please select a Primary Care Physician (from the *Keystone 65 HMO* Doctor and Hospital Directory) and a Primary Dental Office (from the Dental Provider Directory).

SECTION E — **Your Signature —** Please read the information provided, then sign and date your enrollment form. If you are an authorized representative, please provide the information requested.

QUESTIONS?
Call toll-free **1-877-393-6733**
Speech- or hearing-impaired: **1-877-219-5457**
Seven days a week, 8 a.m. to 8 p.m.
www.ibxmedicare.com

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

White – Enrollment Copy **Pink** – Customer Copy

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A To enroll in *Keystone 65 HMO*, please provide the following information:

LAST Name: | FIRST Name: | Middle Initial | ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: MM-DD-YYYY | Sex: ☐ M ☐ F | Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

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**:

E-mail Address:

Requested Action:

ADDITIONS	*CHANGES*	*TERMINATION*
☐ New Subscriber	☐ Name	☐ Termination from plan
☐ Add Spouse	☐ Address	
	☐ Other	

Past Employer/Union:

Name of Employer/Union (Past or Present): _____

_____

Group #: ☐☐☐☐☐☐ Desired Effective Date: MM-DD-YYYY

B Please provide your Medicare insurance information

Please take out your Medicare Card to complete this section.

- Please fill in the blanks so they match your red, white, and blue Medicare card

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number ☐☐☐☐☐☐☐☐☐☐ Sex ☐☐

Is Entitled To | Effective Date

HOSPITAL (Part A) ☐☐-☐☐-☐☐☐☐

MEDICAL (Part B) ☐☐-☐☐-☐☐☐☐

C 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 any more, **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. Do you currently have health insurance? ☐ Yes ☐ No

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

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

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 *Keystone 65 HMO*? ☐ Yes ☐ No

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

Name of other coverage: _____ ID # for this coverage: _____ Group # for this 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): _____

5. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes", please provide your Medicaid number: _____

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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ Other language (please specify) _____
____ Braille or audio tape

Please contact Keystone 65 HMO at 1-877-393-6733 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 1-877-219-5457. However, please be aware that on weekends and holidays from February 15 through September 30, your call may be sent to an answering machine.

D Please choose your providers

Primary Care Physician (check box if current physician) ☐	Physician Code No. ☐☐☐☐☐☐☐☐☐☐ The 10-digit number beneath provider name in directory
Primary Dental Office Name	Primary Dental Provider No. ☐☐☐☐☐☐☐☐☐☐ The 10-digit number beneath provider name in directory

E Please read and sign below

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

Keystone 65 HMO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part A and Part 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 do not 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 special circumstances.

Keystone 65 HMO serves a specific service area. If I move out of the area that *Keystone 65 HMO* 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 *Keystone 65 HMO*, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from *Keystone 65 HMO* 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 *Keystone 65 HMO* coverage begins, I must get all of my health care from *Keystone 65 HMO*, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by *Keystone 65 HMO* and other services contained in my *Keystone 65 HMO* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR *KEYSTONE 65 HMO* 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 *Keystone 65 HMO*, he/she may be paid based on my enrollment in *Keystone 65 HMO*.

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 *Keystone 65 HMO* will release my information including any 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.

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Your Signature:	**Today's Date:** MM-DD-YYYY

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Relationship to Enrollee: _____

Office Use Only

Name of Plan Representative/Agent/Broker (if assisted in enrollment): _____

Group #: _____ Group Name: _____

Effective Date of Coverage: _____

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