

Thank you for your interest in applying for the Regence BlueCross BlueShield Medicare Advantage plan.

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date.

Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th 2011. This will give you a January 1st 2012 effective date for your new plan. Applications must be signed and dated on, or between October 15th and December 7th 2011. If they are signed prior to October 15th they will be returned to you with a new application. If they are received after December 7th, you will not be able to change plans until the next AEP for January 2013.

This application needs to be reviewed and signed by an Agent before it can be submitted to Regence BlueCross BlueShield. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.



Regence

Regence BlueCross BlueShield of Oregon is an independent Licensee of the Blue Cross and Blue Shield Association

PO Box 12625
Salem, OR 97309-0625
1-888-REGENCE
(1-888-734-3623) Fax number 1-888-335-2988
TTY 711

Regence MedAdvantage (PPO) Enrollment Request Form

Please contact Regence MedAdvantage if you need information in another format (Braille).

To enroll in Regence MedAdvantage, please provide the following information:

Please check which plan you want to enroll in:

- Regence MedAdvantage + Rx Enhanced (medical and Rx plan) \$135.00
- Regence MedAdvantage + Rx Classic (medical and Rx plan) \$67.00
- Regence MedAdvantage Basic (medical only plan) \$35.00

LAST Name:			FIRST Name:			Middle Initial			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.			
Birthdate: (mm/dd/yyyy)			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number:			Alternate 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:												

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.

MEDICARE				HEALTH INSURANCE	
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 that you currently have or may owe) by mail or 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, 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 RRB. 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 eligible, 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 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 below.

- Get a 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 Savings

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** (The Social Security/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 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. 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 and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

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 & Phone Number of Institution (number and street): _____

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

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

5. Do you or your spouse work? Yes No

Please check **one** of the boxes below, if you would prefer us to send your information in another format:

Large Print CD Audio Tape

Please contact Regence MedAdvantage at 1-800-541-8981 if you need information in another format. Our office hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 15 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.



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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. 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 qualification required to be in that 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 Regence MedAdvantage at 1-800-541-8981 (TTY users should call 711) to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 15 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week.



STOP

Please read this important information

If you currently have health coverage from an employer or union, joining Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Regence MedAdvantage + Rx Classic or Regence MedAdvantage + Rx Enhanced. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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:

Regence BlueCross BlueShield of Oregon 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.

Regence MedAdvantage serves a specific service area. If I move out of the area that Regence MedAdvantage 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 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 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 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 (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE WILL PAY FOR THE SERVICES.



Please read and sign below

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.

Release of Information: By joining this Medicare health plan, I acknowledge that Regence MedAdvantage 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. 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 authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number () _____

Relationship to Enrollee _____

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: _____

Agent Name Dann Loewenthal Agent Number 0102279-0004

Agent Phone Number (including area code) 541.434.9613

Agent Signature _____



Surepay Authorization



Regence

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Licensee of the Blue Cross and Blue Shield Association

PO Box 12625

Salem OR 97309-0625

**Regence MedAdvantage Basic (PPO)
Regence MedAdvantage +
Rx Classic (PPO)
Regence MedAdvantage +
Rx Enhanced (PPO)**

Remember!

No need to pay now.

**An invoice will be
mailed to you first.**

Making premium payments the easy way--without even writing a check.

With Regence BlueCross BlueShield of Oregon's Surepay program, your bank will automatically deduct your premium payment each month from your personal checking, savings, or money market account.

It's easy to get started. Just follow these steps:

- ♦ Complete and sign the authorization below.
- ♦ **For checking and money market accounts** tape a preprinted check below with "VOID" written across it. **Do not send a deposit slip.**
- ♦ **For business checks**, the name imprinted on the voided check must exactly match the name of the person signing this form. If it does not, we need a letter from your bank saying that you are an authorized signer on the bank account.
- ♦ **For savings accounts** attach a letter from your bank on bank letterhead with your account number and routing numbers.
- ♦ Return the authorization to us at least 30 days prior to your next premium due date.

IMPORTANT - Please pay your premium by check each month until we notify you that your electronic funds transfer has been started. Processing may take up to 60 days. If any premiums are past due, we cannot start your electronic funds transfer.

If you currently have coverage, you will be sent a reminder before the first withdrawal.

If you have any questions, please call Regence BlueCross BlueShield of Oregon at 1 (800) 541-8981.

Authorization Agreement for Monthly Automatic Bank Deduction of Insurance Premium

Please complete this form only if you want premiums deducted from your bank.

Please Print

Name of Applicant	
Medicare Number of Applicant	
I (or we if this is a joint account) authorize Regence BlueCross BlueShield of Oregon (Regence BCBSO) to charge my bank account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I send Regence BCBSO written notification or I give my bank notice in writing that it has ended. I understand that I must give this notice in time to give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.	
Name of Bank	Type of Account: (Select One) <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market
Signature of Bank Account Holder	Date

A preprinted check with "VOID" written across it must be taped to this authorization. NO DEPOSIT SLIPS.

