2027 Blue Shield of California Medicare Advantage Change of Plan Form

Current Blue Shield of California Medicare Advantage Plan members may use this short enrollment form to enroll into a Medicare Advantage Plan offered by Blue Shield of California.

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

I am currently a member of the _____ plan in _____
with a monthly premium of $ _____.

Select the plan you want to join:

Blue Shield Inspire (HMO)
- ☐ Alameda/San Mateo counties ($60 per month)
- ☐ Los Angeles/Orange counties ($0 per month)]
- ☐ Merced/San Joaquin/Santa Clara Stanislaus counties ($61 per month)

Blue Shield 65 Plus (HMO)
- ☐ Los Angeles/Orange counties ($0 per month)
- ☐ Kern County ($0 per month)
- ☐ Riverside County ($0 per month)
- ☐ San Bernardino County ($0 per month)
- ☐ San Diego County ($0 per month)
- ☐ San Luis Obispo/Santa Barbara counties ($70 per month)

Blue Shield Advantage (HMO)
- ☐ San Joaquin County ($20 per month)
- ☐ Sacramento/Placer counties ($19 per month)
- ☐ Los Angeles/Orange counties ($0 per month)
- ☐ San Diego County ($0 per month)

Blue Shield 65 Plus Choice Plan (HMO)
- ☐ Riverside/San Bernardino counties ($0 per month)

Blue Shield AdvantageOptimum Plan (HMO)
- ☐ Los Angeles/Orange counties ($0 per month)

Blue Shield AdvantageOptimum Plan 1 (HMO)
- ☐ San Diego County ($0 per month)

Blue Shield 65 Plus Plan 2 (HMO)
- ☐ Los Angeles/Orange counties ($0 per month)

Blue Shield Value Advantage Plan
****Non-commissionable****
- ☐ Los Angeles County ($0 per month)
- ☐ San Diego County ($0 per month)

I understand that this plan has different health benefits and may have a monthly premium, as stated above.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Member number:

Last name:	**First name:**	**Middle initial (optional):**

Phone number: **Phone type:** ☐ Landline ☐ Mobile

Permanent street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):

Street address:

City: State: ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:

City: State: ZIP code:

Please indicate if you would like to enroll in the Optional Supplemental Dental HMO or Optional Supplemental Dental In-Network Only (INO) plan

☐ Optional Supplemental Dental HMO plan ($16.20 per month) (not available in all plans/service areas; refer to the plan summary of benefits for additional information.)

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 In-Network Only (INO) plan ($49.00 per month) (not available in all plans/service areas; refer to the plan summary of benefits for additional information.) No dentist selection necessary for the Optional Supplemental Dental In-Network Only (INO) plan.

Name of chosen primary care physician (PCP) or clinic (HMO only):

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Blue Shield Customer Service at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m. PT, seven days a week.

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. You can change your preference for delivery at any time.

Your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or you can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

To learn more about your payment options, visit us at **blueshieldca.com/medicarewaystopay** or call Customer Service at **(800) 776-4466 (TTY: 711)**.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

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

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 the Railroad Retirement Board. 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 you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a late enrollment penalty. Many people qualify 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 **(800) 772-1213**. TTY users should call **(800) 325-0778**. You can also apply for Extra Help online at **www.ssa.gov/medicare/part-d-extra-help**.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please read and sign below

Blue Shield of California is a plan that has a contract with the federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield Medicare Advantage Plan, he/she may be paid based on my enrollment in Blue Shield Medicare Advantage Plan.

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 Blue Shield Medicare Advantage Plan 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 people with Medicare aren't 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 Medicare Advantage Plan coverage begins, I must get all of my health care from Blue Shield Medicare Advantage Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield Medicare Advantage Plan and other services contained in my Blue Shield Medicare Advantage Plan *Evidence of Coverage* (EOC) document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES**.

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 (MM/DD/YYYY):**

If you are the authorized representative, you must sign the previous page and provide the following information:

Name:

Address:

City: State: ZIP code:

Phone number:

Relationship to enrollee:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping the enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

Producer/writing agent information:
*Indicates required field.

Appointed agency name:

Appointed agency's Tax ID:*

Producer/writing agent's name:*

Producer/writing agent's **individual NPN**:*

Producer/writing agent's email address:

Producer/writing agent's phone number:

Producer/writing agent's signature:

Date application received by producer:

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