OMB No. 0938-1378
Expires: 12/31/2026

Independence

INDIVIDUAL ENROLLMENT NON-GROUP ELECTION FORM

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items unless marked optional. You can't be denied coverage because you don't fill optional items out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Independence Blue Cross
Medicare Department
P.O. Box 13713
Philadelphia, PA 19101-3713

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Keystone 65 HMO at 1-877-393-6733. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Keystone 65 HMO al 1-877-393-6733 (TTY/TDD: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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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Independence

INDIVIDUAL ENROLLMENT NON-GROUP ELECTION FORM

Please contact Independence Blue Cross if you need information in another language or format (Braille).

A To Enroll in Keystone 65 HMO, Please Provide the Following Information (Unless Marked Optional):

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

Please check the box next to the plan you wish to enroll in:	*(Counties: Chester, Delaware, Montgomery)*	*(Counties: Philadelphia, Bucks)*
	Monthly Premium	Monthly Premium
☐ **Keystone 65 Basic Rx HMO** Medical with Rx 055	$0.00	$0.00
☐ **Keystone 65 Essential Rx HMO-POS** Medical with Rx 060	$31.00	$31.00
☐ **Keystone 65 Focus Rx HMO-POS** Medical with Rx 054 and 053	$15.00	$0.00
☐ **Keystone 65 Liberty Medical-Only HMO** Medical Only (No Rx) 059	$0.00	$0.00
☐ **Keystone 65 Preferred Medical Only HMO** Medical Only (No Rx) 008	$111.00	$111.00
☐ **Keystone 65 Preferred Rx HMO** Medical with Rx 045 and 020	$158.00	$188.00
☐ **Keystone 65 Select Medical Only HMO** Medical Only (No Rx) 050 and 048	$0.00	$20.00
☐ **Keystone 65 Select RX HMO** Medical with Rx 051 and 049	$74.00	$47.00

LAST Name:	FIRST Name:	Middle Initial:
Birth Date: (____ /____ /_____) **(MM/DD/YYYY)**	**Sex:** ☐M ☐F	☐ Mr. ☐ Mrs. ☐Ms.

Phone Number: ( )

Email Address (This question is optional): _____

By voluntarily giving Independence Blue Cross my phone number (including my mobile number) and/or email address, I authorize Independence Blue Cross and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via email, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy.

Permanent Residence Street Address (Don't enter a PO 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 (Only if different from your permanent residence address. P.O. Box is allowed):

Street Address: City: State: ZIP Code:

Emergency Contact: _____

Phone Number: _____ Relationship to You: _____

B Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

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

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	(___ /___ /_____) **(MM/DD/YYYY)**
MEDICAL (Part B)	(____ /____ /____) **(MM/DD/YYYY)**

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

C Paying Your Plan Premium (All Fields In This Section Are Optional)

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

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 having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay Keystone 65 HMO the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option (This question is optional)**:**

☐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: ☐☐☐☐☐☐☐☐☐ Account type:

Bank account number: ☐☐☐☐☐☐☐☐☐☐☐ ☐ Checking ☐ Savings

☐ 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/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.)

D Please Read and Answer These Important Questions (Unless Marked Optional):

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

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Keystone 65 HMO? ☐Yes ☐No

Name of other coverage: _____

Member # for this coverage: _____

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

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

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

4. Do you work? (This question is optional) ☐Yes ☐No

5. Does your spouse work? (This question is optional) ☐Yes ☐No

D Please Read and Answer These Important Questions (Unless Marked Optional):

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

Please check any of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format (This question is optional)**:**

☐ Other language (please specify) _____

☐ Braille

☐ Large print

☐ Audio CD

☐ Data CD

Please contact Independence Blue Cross if you need information in an accessible format or language other than what is listed above. Call toll free 1-877-393-6733 (TTY/TDD: 711), seven days a week, 8 a.m. to 8 p.m. Please note on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

E Please Choose Your Providers (Unless Marked Optional)

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

Primary Care Physician ☐ (check box if current physician) (This question is optional)	Physician Code No. / Group ID _____ The 9-digit number beneath provider name in directory

F Attestation of Eligibility for an Enrollment Period

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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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 U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost 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). 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ 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) _____.

☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)

☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster.

☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage plan (with or without drug coverage).

☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage plan with drug coverage.

If none of these statements applies to you or you're not sure, please contact Independence Blue Cross at 1-877-393-6733 (TTY users should call toll free 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. Please note on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

G IMPORTANT: Read and Sign Below

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

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Keystone 65 HMO.
- By joining this Medicare Advantage Plan, I acknowledge that Keystone 65 HMO will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Keystone 65 HMO coverage begins, I must get all of my medical and prescription drug benefits from Keystone 65 HMO. Benefits and services provided by Keystone 65 HMO and contained in my Keystone 65 HMO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Keystone 65 HMO will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).

  Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association. You must continue to pay your Medicare Part B premium.

Signature:	**Today's Date:** (____ /____ /____) **(MM/DD/YYYY)**

If you're the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

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 an enrollee fill out this form.

Name: _____ Relationship to Enrollee: _____

Signature: _____

For Agents and Brokers Only

Date application received: _____

Plan ID #: _____Effective Date of Coverage: _____

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

Agent Number (NIPR/NPN): _____ General Agency Number:_____FMO ID: ___

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.