



53517

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

Name of Plan you are enrolling in:

Name: _____ **Medicare Number:** _____

Home Phone Number: (_____) _____ - _____

Email Address (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: _____

Please fill out the following: I am currently a member of the _____ plan in Independence Blue Cross with a monthly premium of \$ _____. I would like to change to the plan indicated below. I understand that this plan has different health benefits and a different monthly premium, as shown below.

Choose **ONE** of the plans below by placing a check mark in the box . For more information on coinsurance, copayments, deductibles, and limitations for each plan, see your Summary of Benefits and/or Evidence of Coverage.

Plan Name	Counties: Chester, Delaware, Montgomery	Counties: Philadelphia, Bucks
Keystone 65 Basic Rx HMO (055)	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
Keystone 65 Essential Rx HMO-POS (060)	<input type="checkbox"/> \$31.00	<input type="checkbox"/> \$31.00
Keystone 65 Focus Rx HMO-POS (054 and 053)	<input type="checkbox"/> \$15.00	<input type="checkbox"/> \$0.00
Keystone 65 Liberty Medical Only HMO (059)	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
Keystone 65 Preferred Medical Only HMO (008)	<input type="checkbox"/> \$111.00	<input type="checkbox"/> \$111.00
Keystone 65 Preferred Rx HMO (045 and 020)	<input type="checkbox"/> \$158.00	<input type="checkbox"/> \$188.00
Keystone 65 Select Medical Only HMO (050 and 048)	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$20.00
Keystone 65 Select Rx HMO (051 and 049)	<input type="checkbox"/> \$74.00	<input type="checkbox"/> \$47.00

Name of chosen Primary Care Physician (PCP), clinic or health center: _____

Physician Code No. / Group ID: _____

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

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 (optional):

- Other Language (please specify) _____
- Braille
- Large print
- Audio CD
- Data CD

Please contact Keystone 65 HMO at 1-800-253-4083 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/TDD users should call 711. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.





Please Read This Important Information.

Please Read and Sign Below:

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 my prescription drug event data to Medicare, which 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 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 and other services contained in my 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 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Independence Blue Cross, he/she may be paid based on my enrollment in Keystone 65 HMO.

Benefits underwritten by QCC Insurance Company, 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: (_____ / _____ / _____) (M M / D D / Y Y Y Y)
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If you are the authorized representative, you must sign above and provide the following information:

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*:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

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

Agent Number (NIPR/NPN): _____

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. Use the enclosed return envelope to send your completed form to the plan.

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.