OMB No. 0938-1378
Expires: 7/31/2023

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY PRESCRIPTION DRUG PLAN ENROLLMENT FORM

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug 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 Prescription Drug Plan, you must also have either, or 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 in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them 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:

Horizon Blue Cross Blue Shield of New Jersey
PO Box 10138
Newark, NJ 07101-9633

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

How do I get help with this form?

Call Horizon Blue Cross Blue Shield of New Jersey at 1-888-328-4542. 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 Horizon Blue Cross Blue Shield of New Jersey al 1-888-328-4542 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Section 1- All fields on this page are required

Select the plan you want to join (only one):
☐ Horizon Medicare Blue Rx Saver (PDP)- $28.50 per month
☐ Horizon Medicare Blue Rx Standard (PDP)- $63.80 per month
☐ Horizon Medicare Blue Rx Enhanced (PDP)- $99.50 per month

FIRST name:	LAST name:	
Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ☐☐☐☐☐☐☐☐☐☐

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ ZIP Code: ☐☐☐☐☐

Your Medicare information:

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Horizon Blue Cross Blue Shield of New Jersey?

☐ Yes ☐ No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep Part A or Part B to stay in Horizon Blue Cross Blue Shield of New Jersey.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Horizon Blue Cross Blue Shield of New Jersey will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to Federal statutes 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 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.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2- All fields on this page 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.

☐ Large print

Please contact Horizon Blue Cross Blue Shield of New Jersey at 1-800-391-1906 if you need information in an accessible format other than what's listed above (i.e. Braille or Audio CD). Our office hours are 24 hours a day, 7 days a week. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

E-mail address: _____

By providing your email address, you agree to receive communications from Horizon Blue Cross Blue Shield of New Jersey via email.

Paying your plan premiums

You can pay your monthly plan premium by mail or phone 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). DON'T pay Horizon Blue Cross Blue Shield of New Jersey the Part D-IRMAA.

Premium Payment Schedule (**Choose One -** if you don't select a payment option, we will bill you monthly.)

Please see below for further information regarding paying your premium. **Do not send money now.** If your application is approved, we will bill you based on the payment schedule below.

I would like to be billed:

☐ Get a bill monthly. Pay by mail (check, money order or MoneyGram).

☐ Pay by phone monthly. You can also call Customer Service to make a payment by phone using your checking account. You will need to provide your routing number and checking account number that are printed on the bottom of your checks.

☐ 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 the RRB approves the deduction. In most cases, if Social Security or the RRB accepts your request for automatic deduction, the first deduction from your Social Security or the RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or the RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Agent Use Only

GA ID: ☐☐☐☐☐☐ GA Receipt Date: ☐☐/☐☐/☐☐☐☐ NPN# ☐☐☐☐☐☐☐☐☐

Name of Broker: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Receipt Date: ☐☐/☐☐/☐☐☐☐ (Selling Agent) Phone #: ☐☐☐☐☐☐☐☐☐☐

Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Requested Effective Date of Coverage: ☐☐/☐☐/☐☐☐☐ Agent ID: ☐☐☐☐☐☐

Opportunity ID: ☐☐☐☐☐☐ Location ID: ☐☐☐☐☐☐ Consumer ID: ☐☐☐☐☐☐

Event ID: _________________

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment 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 have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I 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 (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 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 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 disaster.
- ☐ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan* for the first time (*Medicare Advantage plan with prescription drug coverage).
- ☐ In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.
- ☐ I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.
- ☐ I recently lost Medicare Part B but I still have Part A.
- ☐ I have had Medicare prior to now, but am now turning 65.
- ☐ None of these statements apply to me.†

†If none of these statements applies to you or you're not sure, please contact Horizon Blue Cross Blue Shield of New Jersey at 1-888-328-4542 to see if you are eligible to enroll. We are open Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 711.