BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

2022 Blue MedicareRx℠ (PDP) Individual Change Form

Complete this form only if you wish to change your Blue MedicareRx plan option.

You qualify to change your plan option if you meet one of the following requirements:

- It is during the annual enrollment period, October 15 to December 7
- You qualify for Extra Help with your prescription drug costs
- You no longer qualify for Extra Help
- You meet certain special exceptions (see the Enrollment Period Determination section on the next page)

To change to a different Medicare Prescription Drug plan option with Blue MedicareRx:

- Fill out the Change Form online at **YourAZMedicareSolutions.com**

or

- Fill out this form
- Check the plan option you want to change to
- Sign the form
- Mail the completed form to the address below

Your coverage with the new plan option will be effective:

- If we receive your completed form by the end of any month, your new benefit plan will generally begin the first of the following month.
- Selections made during the annual enrollment period (October 15 to December 7) are effective January 1.

Questions?

Visit us online at **YourAZMedicareSolutions.com**

Call Blue MedicareRx:
1-833-229-3593, TTY: **711**, 8 a.m. to 8 p.m., local time
- October 1–March 31: seven days a week
- April 1–September 30: Monday through Friday

Write to:
Blue MedicareRx (PDP) Arizona
P.O. Box 3777
Scranton, PA 18505

Contact your independent certified agent

Y0137_P28902PY22_C CMS Approved 07212021

2022 Blue MedicareRx Individual Change Form

A. Member information (please print clearly)

Last Name: First Name: Middle Initial:

Member Number (Printed on your Blue MedicareRx ID card):	Medicare Number (Printed on your red, white and blue Medicare ID card):

Home Phone Number: ( ) –	Alternate Phone Number (optional): ( ) –	E-mail address:

Permanent Residence Street Address **(P.O. Box is not allowed)**:

City:	State:	ZIP Code:

B. Plan options

I want to transfer from my current Part D plan to the Part D plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the first of the following month. Changes made during the Annual Enrollment Period are effective January 1 of the next year.

Please check the box below for the Blue MedicareRx plan option you wish to change to:

❑ Value $36.20 ❑ Enhanced $139.30

C. Enrollment period determination

Typically, you may enroll or change plan options 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 change your plan option 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. **Note: A choice of effective date is only allowed in certain enrollment situations identified below**. In all other cases, or if you do not specify an effective date, your effective date will be the first of the month after your form is received by the plan.

IF THE STATEMENT YOU SELECT REQUIRES A DATE, PLEASE USE THE FOLLOWING FORMAT:

M	M	D	D	Y	Y	Y	Y

❑ I am enrolling during the annual enrollment period, October 15 to December 7, for a **January 1, 2022 effective date.** (Note: The change form must be received by December 7 for the change to be effective on January 1.)

I AM MOVING OR HAVE MOVED

❑ 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 the following date:

.

Enrollee name: _____

I LOST OR AM LOSING MY COVERAGE OR EXTRA HELP

❑ 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 the following date: ☐☐☐☐☐☐☐☐.

❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on the following 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 HAVE OTHER COVERAGE (AND OTHER REASONS)

❑ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment change because of the natural disaster.

❑ Other special enrollment period not identified above _____

If none of the statements applies to you or if you are not sure, please contact our Blue MedicareRx Medicare Solutions specialists at **1-833-229-3593** (TTY: **711**), 8 a.m. to 8 p.m., local time. October 1–March 31: seven days a week; April 1–September 30: Monday through Friday.

If you would prefer that we send you information in a language other than English or in an accessible format, please contact Blue MedicareRx Member Services at the phone number on the front of this form.

D. Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you 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 (IRMAA), 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 or RRB benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Blue MedicareRx.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a 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**, 7 a.m. to 7 p.m., Monday–Friday. TTY users should call **1-800-325-0778**. You can also apply for Extra Help online at **ssa.gov/prescriptionhelp** or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048. 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 receive a bill each month.

Enrollee name: _____

Select a premium payment option:

❑ Keep my current premium payment option.

❑ Receive a paper bill. **Do not send a premium payment with this application.**

❑ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

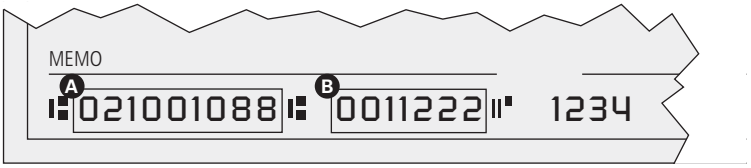
Account holder name: _____

Financial institution: _____

Bank routing number: | | | | | | | | | |

Bank account number: | | | | | | | | | | | | | | | | |

Account type: ❑ Checking ❑ Saving



Ⓐ The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.

Ⓑ Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

❑ 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/EFT deduction may take two or more months to begin. In most cases, if the Social Security/RRB accepts your request for automatic deduction, the first deduction from your Social Security/RRB benefit check will include all premiums due from your enrollment effective date up to the point withholdings begin. If Social Security/RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums. If you do not pay your premium for the months before the deduction takes effect, you may be disenrolled from the plan.

E. Enrollment authorization: By completing this enrollment application, I agree to the following:

After carefully reading all statements in this section, please sign Section F of this form. Keep the copy marked "Enrollee" for your records.

1. Blue MedicareRx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time.

2. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

3. Blue MedicareRx serves a specific service area. If I move out of the area that Blue MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue MedicareRx network pharmacies. Once I am a member of Blue MedicareRx, I have the right to appeal plan decisions about payments or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx when I get it to know which rules I must follow to get coverage.

Enrollee name: _____

4. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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

6. I understand counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

7. **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that Blue MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue MedicareRx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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.

Enrollee name: _____

F. Signature

I want to transfer from my current plan option to the plan option I have selected here. I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this change form, including the information in Section E. 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 by Medicare.

Your signature: _____ **Today's date:** _____

❑ I give permission to the licensed agent identified below to enter my change form online through **YourAZMedicareSolutions.com.**

For authorized representative use only

If you are the **authorized representative,** you **MUST** sign above and provide the following information:

Name (Print): _____ Phone number: (____) _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Relationship to Enrollee: _____

❑ I want all mail for this member sent to me.

For agent use only

Certified Broker/Agent Name (Print): _____

Agent/Broker of Record #:_____

Broker of Record (Print): _____
(Enter the name of the Entity or Person contracted with BCBSAZ)

❑ Check if you have received this **completed** enrollment form with the enrollee's signature from the enrollee. This paper form must be submitted using one of the methods below within **two (2) calendar days** of the date you receive it. Sign and date below when you receive the form from the beneficiary.

Broker/Agent signature: _____

Date form received: _____ Phone number: (____) _____

Check selected submission method and enter information as appropriate:

❑ Paper to online application. Enter online confirmation number:_____

❑ Application faxed. Enter date faxed (keep fax confirmation sheet):_____

❑ Application sent overnight. Be sure to keep the overnight receipt.

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