



# Group Medicare Advantage Enrollment Request Form

*Transit Employees' Health and Welfare Plan*

## Who can use this form?

People with Medicare who want to join a Group 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 Group Medicare Advantage Plan, you must be determined eligible to enroll by your group administrator and also have both:

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

## When do I use this form?

Please refer to your enrollment materials for information on when you can enroll in this Group Medicare Advantage Plan.

Note: If you and your spouse or Medicare-eligible dependent are applying, each of you will need to fill out a separate enrollment request form.

## 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.

## What happens next?

Send your completed and signed form to:

Transit Employees' Health & Welfare Plan  
2701 Whitney Place, Suite 100  
Forestville, MD 20747-3457

Or fax to: 301-568-7302

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-NEW. 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.

**SECTION 1—ALL FIELDS IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)**

Select the plan you want to join:

 CareFirst BlueCross BlueShield Group Medicare Advantage (PPO)**CONTACT INFORMATION**

Employer or Union Group Name:			<b>Employee ID</b>
FIRST Name:	LAST Name:		Middle Initial (optional):
Birth Date:	Sex: <input type="radio"/> Male <input type="radio"/> Female	Home Phone Number:	Mobile Phone (optional):
Permanent Residence Street Address (Don't enter a PO Box):			County:
City:		State:	ZIP Code:
Mailing Address, if different from your Permanent Address (PO Box allowed):			
City:		State:	ZIP Code:
Email Address: (optional)			

**MEDICARE INFORMATION**

Medicare Number:	Part A Effective Date:	Part B Effective Date:
------------------	------------------------	------------------------

**ANSWER THESE IMPORTANT QUESTIONS**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareFirst BlueCross BlueShield Medicare Advantage?  Yes  No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:
-------------------------	----------------------------------	---------------------------------

**SECTION 2—ALL 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 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

Please contact the number listed in your enrollment materials if you need information in an accessible format or language other than what is listed above.

**SECTION 3—IMPORTANT: READ AND SIGN BELOW**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareFirst BlueCross BlueShield Medicare Advantage.
- By joining this Group Medicare Advantage Plan, I acknowledge that CareFirst BlueCross BlueShield Group Medicare Advantage 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 CareFirst BlueCross BlueShield Group Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareFirst BlueCross BlueShield Group Medicare Advantage. Benefits and services provided by CareFirst BlueCross BlueShield Group Medicare Advantage and contained in my CareFirst BlueCross BlueShield Group Medicare Advantage “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareFirst BlueCross BlueShield Group Medicare Advantage 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.

Signature:	Today's Date:
------------	---------------

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

Name:	Address:
Phone Number:	Relationship to Enrollee:

**EMPLOYER GROUP USE ONLY**

Employer or Union Group Name:	
Subgroup Name/Number (if applicable):	Employer Group Number:
Employer Receipt Date:	Authorized Representative Name:

**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 and 1860D-1 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.

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.