Group Medicare Advantage Enrollment Request Form

CareFirst Medicare Advantage

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:

District of Columbia Department of Human Resources

1015 Half Street, S.E. 9th Floor

Washington, DC 20003

Questions?

For eligibility and enrollment questions, call:

District of Columbia Government: 833-556-3163

Monday through Friday, 8:00 am- 5:00 pm ET

For benefit plan questions, call:

CareFirst BlueCross BlueShield Medicare Advantage

833-320-2664 (TTY: 711)

Monday through Friday 8:00 am to 6:00 pm ET

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:
District of Columbia Government

FIRST Name:	LAST Name:	Middle Initial (optional):

Birth Date:	Sex: ◯ Male ◯ 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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

◯ No, not of Hispanic, Latino/a, or Spanish origin ◯ Yes, Mexican, Mexican American, Chicano/a
◯ Yes, Puerto Rican ◯ Yes, Cuban ◯ Yes, another Hispanic, Latino/a, or Spanish origin
◯ **I choose not to answer**

What's your race? Select all that apply.

◯ American Indian or Alaska Native ◯ Asian Indian ◯ Black or African American ◯ Chinese
◯ Filipino ◯ Guamanian or Chamorro ◯ Japanese ◯ Korean ◯ Native Hawaiian
◯ Other Asian ◯ Other Pacific Islander ◯ Samoan ◯ Vietnamese ◯ White
◯ **I choose not to answer**

Select if you want us to send you information in a language other than English.

◯ Spanish

SECTION 2—ALL FIELDS IN THIS SECTION ARE OPTIONAL

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 Group Medicare Advantage.
- I understand that I can be enrolled in only one Medicare Advantage plan at a time—and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA).
- 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 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: District of Columbia Government	
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.