MedicareRx
Prescription Drug Coverage

BlueCross BlueShield of North Carolina
P.O. Box 25190
Durham, NC 27702

2025 Individual Enrollment Form for Experience Health Medicare Advantage Plan (HMO)

Individuals experiencing homelessness:

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

A. Personal Information (exactly as it appears on your Medicare card):

First Name: Middle Initial:

Last Name: Suffix:

Birth Date: (mm/dd/yyyy) / / Sex: ☐ Male ☐ Female

Primary Phone Number: - -

Alternate Phone Number: (optional) - -

Email Address: (optional)

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

City: State: Zip Code:

County:

Mailing Address: (if different from your permanent address. P.O. Box allowed)

City: State: Zip Code:

B. 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; another Hispanic, Latino(a), or Spanish origin
- ☐ Yes; Puerto Rican
- ☐ Yes; Cuban
- ☐ **I choose not to answer.**

What is 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 Hawaii
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I don't know
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

C. Communication Preferences:

Please contact Blue Cross and Blue Shield of North Carolina (Blue Cross NC) if you need information in an alternative language, such as Spanish at 1-833-905-1311 (TTY: 711). Our office hours are 7 days a week, 8 a.m. to 8 p.m.

Select one if you want us to send you information in an accessible format.

- ☐ Braille
- ☐ Large print
- ☐ Audio CD
- ☐ Data CD (Flash drive)

I want to get Plan Materials via email. I have provided my email address above. Once a member, please visit **BlueConnectNC.com** to set your communications preferences.

☐ Yes ☐ No

D. Please check which plan you want to enroll in:

- ☐ **Experience Health**
- ☐ H3777-001-002
- ☐ H3777-001-003
- ☐ H3777-001-004

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E. Please choose the name of a Primary Care Provider (PCP):

Name of Primary Care Provider: If you do not choose a PCP, one will be assigned to you.

Provider Address:

City: State: Zip Code:

PCP Code: (National Provider Identifier #) PCP Phone: - -

(To find an NPI number, go online to our **Provider Directory** at: **BlueCrossNC.com/experience-health**)

☐ Current patient ☐ New patient

F. Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Please note: You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

Name: (as it appears on your Medicare card)

Medicare Number:

Effective Date: (mm/dd/yyyy)

Hospital (Part A): / /

Medical (Part B): / /

G. Paying your plan premium:

Zero Premium Plans: If we determine that you owe a late enrollment penalty or if you currently have a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail 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.

Plans with premiums: You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe by mail 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 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 Blue Cross NC the Part D-IRMAA.

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Please select a premium payment option:

- ☐ Get a bill each month.
- ☐ Automatic deduction from your monthly Social Security benefit check.
- ☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

Please note: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

H. Please read and answer these important questions:

☐ Yes ☐ No 1. Do you have End Stage Renal Disease (ESRD)?
Note: Answering this question does not affect your eligibility to enroll.

☐ Yes ☐ No 2. Do you work?

☐ Yes ☐ No 3. Does your spouse work?

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee health benefits coverage, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Experience Health Medicare Advantage (HMO)? **If "yes,"** please list your other coverage and your identification (ID) number(s) for this coverage.

ID # for this coverage: _____

Group # for this coverage: _____

Name of other coverage: _____

☐ Yes ☐ No 4. Are you enrolled in your state Medicaid program? **If "yes,"** please provide your Medicaid number.

Medicaid number

☐☐☐☐☐☐☐☐☐☐☐

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I. Please read this important information:

If you currently have health coverage from an employer or union, joining Experience Health Medicare Advantage (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Experience Health Medicare Advantage (HMO). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

J. Eligibility for an enrollment period:

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box on the left 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.

☐ Annual Enrollment Period (AEP). Your plan effective date will be **January 1**.

☐ 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 the service area for my current plan **or** I recently moved and this plan is a new option for me.

Where are you moving from:

County: _____ State: _____

I moved on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ I recently was released from incarceration.

I was released on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I am moving into, 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 facility on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

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☐ I recently left a PACE program on:
(Programs of All-Inclusive Care for the Elderly)

I recently left a PACE program on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently involuntarily lost my creditable prescription drug coverage. (Coverage as good as Medicare's)

I lost my drug coverage on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ I am leaving employer or union coverage on:

(mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ I belong to a pharmacy assistance program provided by my state.

☐ I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

My plan is ending on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

My plan is with:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan.

I was disenrolled from an SNP on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

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☐ 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.

☐ I recently obtained lawful presence status in the United States. I got this status on: (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on: (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ 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: (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

☐ 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.

☐ None of these statements apply to me.*

Other Special Enrollment Period (SEP) reason:

_____

_____

*If you need further assistance figuring out if you're eligible to enroll, please contact Experience Health Medicare Advantage (HMO) at: **833-905-1311** or, for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m. between October 1 – March 31; 8 a.m. to 8 p.m. Monday – Friday between April 1 – September 30.

K. STATEMENT OF UNDERSTANDING

By completing this enrollment application, I agree to the following:

1. 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 and/or Prescription Drug plan. **If I am enrolled in a Medicare Supplement Plan, I must disenroll in order to not duplicate benefits.**
2. I must keep both Hospital (Part A) and Medical (Part B) to stay in the Experience Health Medicare Advantage (HMO) Plan.

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3. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
4. 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.
5. I understand that when my Experience Health Medicare Advantage (HMO) coverage begins, I must get all of my medical benefits from Experience Health Medicare Advantage (HMO). Benefits and services provided by Blue Cross NC and contained in my Experience Health Medicare Advantage (HMO) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Cross NC will pay for benefits or services that are not covered.
6. Blue Cross NC serves a specific service area. If I move out of the area that Blue Cross NC serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
7. Once I am a member of Blue Cross NC, I have the right to appeal plan decisions about payment or services if I disagree.
8. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Blue Cross NC, he/she may be paid based on my enrollment in Blue Cross NC.

Release of Information

By joining this Medicare Advantage Plan, I acknowledge that Blue Cross NC 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).

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.

By sharing your phone number, you agree to calls or text from Blue Cross NC or its partners. Blue Cross NC and its partners will not utilize your number for commercial or marketing purposes. Calls could include prerecorded or robot voiced calls.

L. Applicant Agreement:

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 form; and 2) documentation of this authority is available upon request from Medicare.

Your Signature: _____ ☐☐ / ☐☐ / ☐☐☐☐

Today's Date: (mm/dd/yyyy)

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

Name:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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Address:

City: State: Zip Code:

Phone Number: - -

Relationship to Enrollee:

M. 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: _____ National Producer Number: _____
(Agents / Brokers only)

LICENSED AGENT USE ONLY

Agents must submit a signed enrollment form within 24 hours of receipt.

Agent's Signature: _____ Print Agent's Name: _____

Date Application Received: / / NPN#: _____
(mm/dd/yyyy) Required

Phone Number: _____ Agent Number: _____

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact 1-833-905-1311 (TTY: 711) for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Llame al 1-833-905-1311 (TTY: 711) para obtener ayuda.

Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Experience Health Medicare Advantage (HMO) depends on contract renewal.

Experience Health
Medicare Advantage℠ (HMO)

Form Approved OMB# 0938-1421

BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-905-1311 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llámenos al 1-833-905-1311 (TTY: 711). Alguien que hable inglés le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的口译服务，帮助您解答关于我们健康或药物计划的任何疑问。要获得口译员服务，请致电 1-833-905-1311 (TTY: 711)。会有讲英文/中文的工作人员帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康保險或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-905-1311 (TTY: 711) 聯絡我們。我們講英語/您的語言的人員將樂意為您提供幫助。這項服務是免費的。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-905-1311 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng English o Tagalog. Ito ay libreng serbisyo.

French: Nous fournissons gratuitement les services d'un interprète pour répondre à toutes les questions que vous pouvez avoir sur notre régime d'assurance maladie ou de médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-905-1311 (TTY: 711). Un interlocuteur qui parle anglais/français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về kế hoạch sức khỏe hoặc thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-905-1311 (TTY: 711) sẽ có nhân viên nói tiếng Anh/Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Die Dolmetscher erreichen Sie unter 1-833-905-1311 (TTY: 711). Man wird Ihnen dort auf Deutsch oder Englisch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 처방약 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-905-1311 (TTY: 711) 번으로 문의해 주십시오. 영어/한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно плана медицинского страхования или плана получения лекарств, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-905-1311 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-английски или на вашем языке. Данная услуга бесплатная.

Arabic: يمكننا تقديم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلةتتعلق بخطة الصحة أو الأدوية الخاصة بنا. وللحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على رقم 1-833-905-1311 (TTY: 711) . وسوف يساعدك شخص يتحدث اللغة الإنجليزية / العربية. هذه خدمة مجانية.

Experience Health
Medicare Advantage℠ (HMO)

Form Approved OMB# 0938-1421

BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

Hindi: हमारी स्वास्थ्य या दवा योजना के बारे मे आपके कसिी भी प्रश्न का जवाब देने के लिए हमारे पास मुफ्त में दुभाषयिा सेवाएँ उपलब्ध है. एक दुभाषयिा प्राप्त करने के लिए, बस हमें 1-833-905-1311 (TTY: 711) पर फोन करें. अंग्रेजी/हन्दिी बोलने वाला व्यक्तआिपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-905-1311 (TTY: 711). Un nostro incaricato che parla inglese/italiano vi fornirà l'assistenza necessaria. Il servizio è gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que você tiver acerca de nosso plano de saúde ou de medicação. Para obter um intérprete, contate-nos pelo número 1-833-905-1311 (TTY: 711). Você encontrará alguém que fale o idioma inglês ou português para ajudá-lo. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan asirans maladi oswa asirans medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-905-1311 (TTY: 711). Yon moun ki pale Anglè/Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza należy zadzwonić pod numer 1-833-905-1311 (TTY: 711). Osoba znająca polski i angielski udzieli Państwu pomocy. Usługa ta jest bezpłatna.

Japanese: 弊社の健康保険または処方薬保険に関するあらゆるご質問にお答えするために、無料の通訳サービスをご用意しております。通訳をご希望の場合は、1-833-905-1311(TTY: 711) までお電話ください。日本語または英語を話す担当の者が支援いたします。これは無料のサービスです。

Y0079_13000_C PA 08312022
U12555h, 8/24

Form CMS-10802 (Expires 12/31/25)