HIGHMARK

MEDICARE ADVANTAGE

2025

Enrollment Application

BlueSaver HMO
Senior Blue HMO
Forever Blue PPO
Freedom PPO

Western New York

Apply with this form, online or by phone. If you have any questions, we're here to help!

medicare.highmark.com

1-866-456-8140
(TTY 711)

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 8 p.m., Monday – Friday**

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

OMB No. 0938-1378
Expires: 6/30/2026

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a 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 Medicare Advantage Plan, you must also have 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 and 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?

Fill out this form online at medicare.highmark.com or mail your completed and signed form to:

Highmark Blue Cross Blue Shield

P.O. Box 4208

Buffalo, NY 14240-9800

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

How do I get help with this form?

Call Highmark at 1-866-456-8140.
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 espanol: Llame a Highmark al 1-866-456-8140 (los usuarios de TTY pueden llamar 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en espanol y un representate estara disponible para asistirle.

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.

Section 1 — All fields on this page are required unless marked optional

Please check which plan you want to enroll in:

- ☐ **BlueSaver (HMO)**
  $ 0 premium per month
- ☐ **Senior Blue 651 (HMO)**
  $ 101 premium per month
- ☐ **Senior Blue 601 (HMO)**
  $ 0 premium per month
- ☐ **Senior Blue Select (HMO)**
  $ 40 premium per month
- ☐ **Senior Blue Basic (HMO)**
  $ 0 premium per month
- ☐ **Forever Blue 751 (PPO)**
  $ 197 premium per month
- ☐ **Forever Blue Value (PPO)**
  $ 131 premium per month
- ☐ **Freedom Nation (PPO)**
  $ 30 premium per month
- ☐ **Freedom Valor (PPO)**
  $ 0 premium per month
- ☐ **Freedom Nation Prestige (PPO)**
  $ 52 premium per month

First Name **Last Name** **Middle Initial (optional)**

Birth Date M M / D D / Y Y Y Y

Sex ☐ M ☐ F

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 **Please provide your Medicare number as shown on your red, white and blue Medicare Health Insurance card.**

_ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Highmark?

☐ Yes ☐ No

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

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.

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

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

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **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 use a different term_____ ❑ I don't know ❑ **I choose not to answer**

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

☐ I would like to receive my materials in a language other than English

☐ I would like to receive my materials in an accessible format (Braille, Large Print, Data CD, Audio CD, etc.)

Please contact Highmark at 1-866-456-8140 if you need information in an accessible format or language other than English. TTY users should call 711. Our office hours are:

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

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide Medicaid number:

List your primary care physician (PCP), clinic, or health center:

Address of primary care physician (PCP), clinic, or health center:

☐ I am a current patient of this provider.

Please provide your e-mail if you'd like communications related to health education, reminders, and other information (Optional).

E-mail:

These emails may include sensitive health information specific to your needs. If you opt in to receive emails, there is a chance that emails sent to you could be monitored, intercepted, read, and/or changed by an unauthorized third party before reaching your email inbox, and that it is possible that information intended for you could go to the wrong person or that your electronic accounts could be hacked. By opting in, you understand and accept these risks.

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. Section 1851 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.

Attestation of 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 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.

New to Medicare or a Change To Your Coverage

☐ I am making my annual enrollment period election (October 15 - December 7).

☐ I am new to Medicare.

☐ I recently involuntarily lost my creditable prescription coverage ("creditable" means coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).

☐ I am leaving or have left employer or union coverage on _____ (insert date).

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

Recent Change in Residence

☐ I recently moved or plan to move outside of the service area for my current plan, or I recently moved or plan to move and this plan is a new option for me _____ (insert move date).

☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).

☐ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home).

I moved/ will move into/ out of the facility on _____ (insert date).

☐ I recently obtained lawful presence status in the U.S. I got this status on _____ (insert date).

☐ I recently was released from incarceration. I was released on _____ (insert date).

Change in Income or Special Needs/Plan Qualifications

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

☐ I recently left a PACE plan (Program of All-Inclusive Care for the Elderly) on _____ (insert date).

☐ 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 the SNP on _____ (insert date).

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, lost Medicaid) on _____ (insert date).

Other Reason

☐ I am in a plan that is identified as a consistent poor performer.

☐ 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 am enrolling in a 5-Star Medicare plan.

☐ None of the above apply.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month, quarterly, biannually, or annually. **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.**

Please select your premium payment option:

Information about EFT and eBill will be included with your first bill.

I would like to receive a bill:

❑ Monthly ❑ Quarterly ❑ Semi-Annually

❑ Annually

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from:

❑ Social Security

❑ RRB

(The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.)

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 Highmark the Part D-IRMAA.

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this Highmark Medicare Advantage plan.
- By joining this Medicare Advantage Plan, I acknowledge that Highmark 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 above).
- I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this Highmark plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 Highmark coverage begins, I must get all of my medical and prescription drug benefits from Highmark. Benefits and services provided by Highmark and contained in my Highmark "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Highmark 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 are the authorized representative, you must sign above and provide the following information:

Name

Address

Phone Number ( )

Relationship to Enrollee

Agent, Broker, or Third Party Use Only

Broker/Agent/Third Party Name: _____

NPN (if applicable): _____

Relationship to Enrollee: _____

Effective Date of Coverage: _____

Date Received: _____

HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY: 711)

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

我們免費提供口譯服務，爲您解答有關我們健康計畫或藥物計畫的任何疑問。若要獲得口譯服務，只需撥打您所在州的電話號碼即可。講漢語的工作人員可爲您提供協助。此項服務免費。

Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na posibleng mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang ang numerong ibinigay para sa estadong tinitirhan mo. May taong nagsasalita ng Tagalog na makakatulong sa iyo. Isa itong libreng serbisyo.

Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime d'assurance maladie ou d'assurance médicaments. Pour obtenir les services d'un interprète, il vous suffit d'appeler le numéro correspondant à votre État de résidence. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc của quý vị về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi số được cung cấp cho tiểu bang cư trú của quý vị. Ai đó nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

Wir verfügen über kostenlose Dolmetschdienste, damit Sie alle eventuellen Fragen zu unserer Krankenversicherung oder zur Medikamenten-Zusatzversicherung klären können. Rufen Sie hierzu einfach die Nummer für den Bundesstaat an, in dem Sie Ihren Wohnsitz haben. Jemand, der Deutsch spricht, wird Ihnen behilflich sein. Dies ist ein kostenloser Service.

لدينا خدمات ترجمة فورية مجانية للإجابة عن أي أسئلة قد تراودك حول خطتنا الصحية أو الدوائية. للحصول على مترجم فوري، فقط اتصل بالرقم المقدم للولاية التي تقيم فيها. ويمكن لشخص يتحدث العربية مساعدتك. هذه خدمة مجانية.

건강 또는 약물 플랜에 대한 귀하의 질문에 답변해 드릴 수 있는 무료 통역 서비스를 제공해 드립니다. 통역사를 구하려면 거주하시는 주의 전화 번호로 문의하십시오. 한국어을(를) 말할 수 있는 직원이 도와드릴 수 있습니다. 이 서비스는 무료로 제공합니다.

Мы предоставляем бесплатные услуги устного перевода, чтобы помочь вам получить ответы на любые вопросы, которые могут у вас возникнуть в отношении нашего медицинского плана или плана лекарственных препаратов. Чтобы заказать услуги переводчика, просто позвоните по номеру, указанному для штата, в котором вы проживаете. Один из наших переводчиков, специализацией которого является русский язык, поможет вам. Эта услуга предоставляется бесплатно.

हमारे पास हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ्त दुभाषिया सेवाएँ हैं। एक दुभाषिया प्राप्त करने के लिए, बस अपने निवास स्थान की स्टेट के लिए दिए गए नंबर पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह एक निःशुल्क सेवा है।

Disponiamo di servizi di interpretariato gratuiti per rispondere a ogni sua domanda riguardo al suo piano sanitario o farmaceutico. Per ottenere l'assistenza di un interprete, chiami il numero fornito per il suo stato di residenza. Qualcuno che parla italiano la aiuterà. Il servizio è gratuito.

Temos serviços de interpretação gratuitos para esclarecer suas dúvidas sobre nosso plano de saúde ou de medicamentos. Para contar com um intérprete, ligue para o número fornecido para o seu estado de residência. Alguém que fale Português pode ajudar você. Este é um serviço gratuito.

Nou gen sèvis entèpretasyon gratis pou reponn ak nenpòt kesyon ou ta ka genyen sou plan asirans sante oswa medikaman nou an. Pou jwenn yon entèprèt ede w, senpleman rele nimewo ki koresponn ak Eta kote w rete a. Yon moun ki pale Kreyòl Ayisyenap ede w. Sèvis sa a gratis.

Dysponujemy darmowymi usługami tłumaczeniowymi, dzięki którym może Pan/Pani uzyskać odpowiedzi na pytania dotyczące naszego planu zdrowia lub leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka. Ktoś, kto zna język polsku, może Panu/Pani pomóc. Ta usługa jest darmowa.

当院では、無料の通訳サービスを用意し、治療や投薬計画に関するご質問にお答えしています。通訳を手配したい場合は、お住まいの州で指定された番号までお電話でご連絡ください。日本語話せる者が対応をお手伝いします。サービスは無料でご利用いただけます。