BlueCross BlueShield of North Carolina
PO Box 25190 | Durham, NC | 27702

Blue Medicare PPO℠

MedicareRx Prescription Drug Coverage

2026 Individual Enrollment Form for Medicare Advantage PPO Plan

All fields on this form are required (unless marked optional).

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

First Name | Middle Initial | Last Name | Suffix

Primary Phone Number

Sex
☐ Male ☐ Female

Alternate Phone Number (Optional)

Date of Birth (Month, Day, Year)

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

City | State | Zip Code | County

Email Address (Optional)

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

City | State | Zip Code

SECTION B 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 1-800-665-8037 (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 ☐ Audio CD

☐ Large print ☐ Data CD (Flash drive)

I want to get Plan Materials via email. I have provided my email address above.

☐ Yes ☐ No

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.

Once you become a member, please visit BlueConnectNC.com to create your Blue Connect member portal account. With Blue Connect, you can sign-up to receive health plan notices, account updates, and more via email and text.

To stop receiving text messages, reply STOP to the message you receive on your mobile phone or opt out in Blue Connect.

SECTION C Please check which plan you want to enroll in

I understand by enrolling in a Blue Cross Medicare Advantage Plan, I will be automatically disenrolled from my current Medicare Advantage Plan (MA/MAPD) or Part D Prescription Drug Plan (PDP) upon the effective date selected.

Blue Medicare PPO Enhanced

☐ H3404-003-001

☐ H3404-003-002

SECTION D 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 a PCP code, go online to **BlueCrossNC.com/members/medicare/find-care**)

☐ Current patient ☐ New patient

SECTION E 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)

Hospital (Part A)

Medicare Number

Medical (Part B)

Effective Date: (Month, Day, Year)

SECTION F 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 each month. You can also choose to pay your premium by automatic deduction from your Social Security or 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.

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.

SECTION G 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 3. Does your spouse work?

☐ No

☐ Yes 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 Blue Medicare PPO? **If "yes,"** please list your other coverage and your identification (ID) number(s) for this coverage.

☐ No

Name of other coverage

ID Number for this coverage

Group Number for this coverage

☐ Yes 4. Are you enrolled in your state Medicaid program? **If yes,** please provide your Medicaid number.

☐ No

Medicaid Number

Effective Date: (Month, Day, Year)

SECTION H Please read this important information

If you currently have health coverage from an employer or union, joining Blue Medicare PPO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Medicare PPO. 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.

SECTION I 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 (Month, Day, Year)

Choose your plan's effective date

0 1 — — —

(Month, Day, Year)

☐ I recently was released from incarceration.

I was released on (Month, Day, Year)

☐ 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:

(Month, Day, Year)

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

I recently left a PACE program on

(Month, Day, Year)

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

I lost my drug coverage on

(Month, Day, Year)

Choose your plan's effective date

0 1 — — —

(Month, Day, Year)

☐ I am leaving employer or union coverage on

(Month, Day, Year)

Choose your plan's effective date

0 1 — — —

(Month, Day, Year)

☐ 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

(Month, Day, Year)

Choose your plan's effective date

0 1 — — —

(Month, Day, Year)

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

My plan is ending on

__ __ — __ __ — __ __ __ __

(Month, Day, Year)

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

__ __ — __ __ — __ __ __ __

(Month, Day, Year)

Choose your plan's effective date

__ __ — 0 1 — __ __ __ __

(Month, Day, Year)

☐ 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

__ __ — __ __ — __ __ __ __

(Month, Day, Year)

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

__ __ — __ __ — __ __ __ __

(Month, Day, Year)

☐ 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

__ __ — __ __ — __ __ __ __

(Month, Day, Year)

☐ 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 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

__ __ — __ __ — __ __ __ __

(Month, Day, Year)

☐ None of these statements apply to me.*

_____

Other Special Enrollment Period (SEP) reason

* If none of these statements applies to you or you're not sure, please contact Blue Cross NC at **1-800-665-8037 (TTY: 711)** to see if you are eligible to enroll. We are open 7 days a week, 8 a.m. to 8 p.m.

SECTION J 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 Blue Medicare PPO.
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 Blue Medicare PPO coverage begins, I must get all of my medical and prescription drug benefits from Blue Medicare PPO. Benefits and services provided by Blue Cross NC and contained in my Blue Medicare PPO "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 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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.

SECTION K 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.

X _____ __ __ — __ __ — __ __ __ __

Your Signature | Today's Date (Month, Day, Year)

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

Name

Address

City | State | Zip Code

__ __ __ — __ __ __ — __ __ __ __

Phone Number | Relationship to Enrollee

SECTION L 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.

First Name | Last Name

Relationship to enrollee:

☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized Representative

☐ Other ☐ Self

X _____

Signature | National Producer Number (Agents/Brokers only)

Licensed Agent Use Only

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

X

Agent's Signature

Print Agent's Name

Date Application Received (Month, Day, Year)

NPN Number (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 1-800-665-8037 (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 1-800-665-8037 (TTY: 711) para obtener ayuda.

Blue Cross and Blue Shield of North Carolina is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

Blue Medicare PPO℠

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

BlueCross BlueShield of North Carolina

English
ATTENTION: If you speak any of the following languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-494-7647 (TTY: 711), or speak to your provider.

Spanish / Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-494-7647 (TTY: 711) o hable con su proveedor.

Chinese / 中文
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-494-7647 (TTY: 711) 或咨询您的服务提供商。

Vietnamese / Việt
LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cấp miễn phí. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-494-7647 (Người khuyết tật: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Korean / 한국어
알림: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-494-7647 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

French / Français
ATTENTION: Si vous parlez français, vous pouvez bénéficier de services d'assistance gratuits. Vous avez également à votre disposition des outils et services supplémentaires vous permettant de fournir des informations dans un format accessible, sans frais. Appelez le 1-877-494-7647 (TTY: 711) ou parlez à votre fournisseur.

Arabic / العربية
تنبيه: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفرمساعدة وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. يُرجى الاتصال على الرقم 1-877-494-7647 (TTY: 711) أو تحدث مع مزود الخدمة الخاص بك.

Hmong / Lus Hmoob
LUG CEEV TSHWJ XEEB: yog has tas koj has lug Hmoob muaj cov kev paab cuam txhais lug pub dlawb rua koj. Cov kev paab hab cov kev paab cuam ntxiv kws tsim nyog txhawm rua muab lug qha paub ua cov hom ntaub ntawv kws tuaj yeem nkaag cuag tau rua los kuj yeej tseem muaj paab dlawb tsis xaam tug nqe dlaab tsi tuab yaam nkaus. Hu rua 1-877-494-7647 (TTY: 711) los yog thaam nrug koj tug kws muab kev saib xyuas khu mob.

Russian / РУССКИЙ
ВНИМАНИЕ: Если Вы говорите на русском, то Вам доступны бесплатные услуги языковой поддержки. Соответствующие инструменты и информационные сервисы также предоставляются бесплатно. Позвоните по телефону 1-877-494-7647 (TTY: 711) или обратитесь к своему поставщику услуг.

Blue Medicare PPO℠

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

BlueCross BlueShield of North Carolina

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-494-7647 (TTY: 711) o makipag-usap sa iyong provider.

Gujarati / ગુજરાતી
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ તો, મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-877-494-7647 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Mon-Khmer, Cambodian / ភាសាខ្មែរ
កំណត់ចំំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មសមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បានក៏មានផ្តល់ជូនដោយឥតគិតថ្លៃផងដែរ។ សូមទូរស័ព្ទទៅលេខ 1-877-494-7647 (TTY: 711) និយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

German / Deutsch
WICHTIGER HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-494-7647 (TTY: 711) oan oder sprechen Sie mit Ihrem Provider.

Hindi / हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-494-7647 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Laotian / ລາວ
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-494-7647 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Japanese / 日本語
お知らせ：日本語をお話しの場合、無料の言語支援サービスをご利用いただけます。アクセス可能な形式で情報を提供するための適切な補助的なサポートやサービスも無料でご利用いただけます。1-877-494-7647 (TTY: 711) にお電話いただくか、プロバイダーにお問い合わせください。