Independence

Keystone 65 HMO

EMPLOYER GROUP APPLICATION AND CHANGE FORM

When this application refers to "Keystone 65," it means Keystone 65 HMO or Keystone 65 HMO-POS.

Please contact Independence Blue Cross if you need information in another language or format (Braille).

Easy step-by-step instructions for filling out this Keystone 65 enrollment form

SECTION A Personal Information — Provide the personal information requested. Then check the box in front of your requested action and provide information about your employer or union.

SECTION B Medicare Insurance Information — Use your Medicare card to complete this section.

SECTION C Important Questions — Please answer the questions in this section.

SECTION D Choose Your Providers — Please select a primary care physician (from the Keystone 65 Provider Directory) and a primary dental office (from the Dental Provider Directory).

SECTION E Your Signature — Please read the information provided, then sign and date your enrollment form. If you are an authorized representative, please provide the information requested.

QUESTIONS?

Call toll-free **1-866-319-5777**
Speech- or hearing-impaired: **711**
Seven days a week, 8 a.m. to 8 p.m.
www.ibxmedicare.com

Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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A To enroll in Keystone 65, please provide the following information:

LAST Name: FIRST Name: Middle Initial:

Birth Date: (__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

Sex: ☐ M ☐ F

☐ Mr. ☐ Mrs. ☐ Ms.

Home Phone Number: ( )

Email Address (optional): _____

By voluntarily giving Independence Blue Cross my phone number (including my mobile number) and/or email address, I authorize Independence Blue Cross and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via email, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy*.

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

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency Contact: _____

Phone Number: ( ) Relationship to You:

Requested Action:

ADDITIONS
☐ New Subscriber

CHANGES
☐ Name ☐ Address ☐ Other

Employer/Union:
Name of Employer/Union (Past or Present): _____

_____

Group #: _____ Desired Effective Date: (__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

B 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.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To: Effective Date:

HOSPITAL (Part A) (__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

MEDICAL (Part B) (__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

C Please read and answer these important questions:

1. Do you currently have health insurance? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

2. Will you have other prescription drug coverage (like VA, TRICARE) in addition to *Keystone 65*? ☐ Yes ☐ No

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If "yes," please provide your Medicaid number: _____

5. Do you work? ☐ Yes ☐ No

6. Does your spouse work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Other language (please specify) _____
☐ Braille
☐ Audio tape

Please contact Keystone 65 at 1-866-319-5777 if you need information in another format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY/TDD users should call 711. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail*.

D Please choose your providers

Primary Care Physician (check box if current physician*) ☐	Physician Code No. _____ The 9-digit number beneath provider name in directory
Primary Dental Office Name	Primary Dental Provider No. _____ The 9-digit number beneath provider name in directory

E Please read and sign below:

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

I must keep both Hospital (Part A) and Medical (Part B) to stay in Keystone 65 HMO.

By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Keystone 65 HMO 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 Keystone 65 HMO coverage begins, I must get all of my medical and prescription drug benefits from Keystone 65 HMO. Benefits and services provided by Keystone 65 HMO and contained in my Keystone 65 HMO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Keystone 65 HMO 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: (___/___/_____) (M M / D D / Y Y Y Y)

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

Name: _____

Address: _____

Phone Number: ( )

Relationship to Enrollee: _____

Office Use Only

Name of Plan Representative/Agent/Broker (if assisted in enrollment): _____

Group #: _____ Group Name: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

*Answering this question is your choice. You can't be denied coverage because you don't fill it out.