Blue Cross® Blue Shield® of Arizona
Plan Change Request Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

This Plan Change Form can only be used for change from like plan to like plan: HMO to HMO

To make a change in the Medicare Advantage plan you have with Blue Cross Blue Shield of Arizona (BCBSAZ) fill out the plan change form to make your choice. Enter the plan information you want below and sign the form.

Changes to health plans can only occur at certain times during the year. From October 15 to December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 to March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

Name of Plan You are Applying For:			
LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Member Number:		Home Phone Number:	
Permanent Street Address *(P.O. Box is not allowed):*			
City:	State:	ZIP Code:	County:
Mailing Address *(only if different from your Permanent Street Address):*			
City:	State:		ZIP Code:

Please fill out the following:

I am currently a member of the _____ plan in BCBSAZ with a monthly premium of $_____.

I would like to change to the _____ plan in BCBSAZ. I understand that this plan has different health benefits and a monthly premium of $_____.

Name of chosen Primary Care Provider (PCP):

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:

☐ Spanish ☐ Large Print ☐ Alternate Format _____

Please contact Member Services at **480-937-0409** (in Arizona) or toll-free **1-800-446-8331** if you need information in an accessible format or language other than what is listed above. Our office hours are from 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30; and seven days a week from October 1 to March 31. TTY users should call **711.**

PAYING YOUR PLAN PREMIUM AND/OR LATE ENROLLMENT PENALTY

You can pay your monthly plan premium and/or any late enrollment penalty you have or may owe by mail, Electronic Funds Transfer (EFT) or credit card. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay BCBSAZ the Part D-IRMAA.

People with limited incomes may qualify for ***Extra Help*** to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this ***Extra Help***, contact your local Social Security office, or call Social Security 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for ***Extra Help*** online at ww.socialsecurity.gov/prescriptionhelp. If you qualify for ***Extra Help*** with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Keep my current premium payment option.

☐ Receive a paper bill. **Do not send a premium payment with this application.**

☐ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

Account holder name: _____

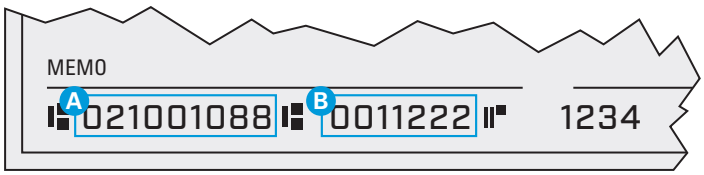
Financial institution: _____

Bank routing number: | | | | | | | | | |

Bank account number: | | | | | | | | | | | | | | | | |

Account type: ☐ Checking ☐ Savings

Ⓐ The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.



Ⓑ Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

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

(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, we will send you an invoice until the deductions from Social Security or RRB are approved, which can take 2-3 months. If Social Security or RRB does not approve your request for automatic deduction, we will continue to send you an invoice for your monthly premiums.)

PLEASE READ AND SIGN BELOW

BCBSAZ is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BCBSAZ, he/she may be paid based on my enrollment in BCBSAZ.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BCBSAZ will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date BCBSAZ coverage begins, I must get all of my health care from BCBSAZ, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCBSAZ and other services contained in my BCBSAZ Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BCBSAZ WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature: **X**_____ 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: _____

Office Use Only:

Member ID #: _____ Plan Effective Date: _____ ICEP/IEP: _____ AEP: _____ OEP: _____

SEP: ____ / SEP Reason: _____ Not Eligible: ____ Enrollment Rep: _____ Completed Date: _____

For Use by Agent/Broker:

Certified Agent Name (Print): _____ Agent/Broker #:_____

Broker of Record*: _____ Requested Effective Date: _____

Agent/Broker Signature: _____

Date Received:_____ Phone Number: _____

**Enter the Name of the Entity contracted with BCBSAZ*

BCBSAZ offers BlueJourney PPO Medicare Advantage plans. BCBSAZ Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Best Life Classic and Plus HMO plans.

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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 1-800-446-8331. 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 llame al 1-800-446-8331. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-446-8331。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康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 1-800-446-8331。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

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 1-800-446-8331. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-446-8331. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-446-8331 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-446-8331. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-446-8331 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-446-8331. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-446-8331. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-446-8331 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी 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 1-800-446-8331. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-446-8331. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-446-8331. Yon moun ki pale 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 znającego język polski, należy zadzwonić pod numer 1-800-446-8331. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-446-8331 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Navajo: T'áá hait'éego da ats'íís baa'áhayą́ doodago azee' aanídaa'nił́ nihinaaltsoos bee hadadít'éhígíí bąąh na'ídikid nee hóló̧go da nihi éí ata' halne'í bee áka'anída'awo'í t'áá jíík'eh nihee hóló. Ata' halne'í ła' yíníkeedg kohjį' 1-800-446-8331 nihich'į' hodíilnih. T'áá háida Bilagáana Bizaad yee yáłti'ígíí ła' niká'iilyeed dooleeł. Díí t'áá jiik'eh bee niká'iilyeed dooleeł.

NOTES:

NOTES:

Not a member yet?

Contact our Licensed Medicare Consultants:

1-888-274-0367, TTY: 711

Or contact your broker

Existing Members call:

480-937-0409 (in Arizona)

or toll-free at **1-800-446-8331, TTY: 711**

October 1 to March 31:
Seven days a week, 8 a.m. to 8 p.m.

April 1 to September 30:
Monday through Friday, 8 a.m. to 8 p.m.