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For the health of all.

Platinum Blue℠ (Cost) Enrollment Form

Platinum Blue is a Medicare Cost product offered by Blue Cross and Blue Shield of Minnesota (Blue Cross), an organization licensed by the state of Minnesota that holds a contract with the Centers for Medicare & Medicaid Services (CMS) to offer this product.

Enrollment Form Instructions

Please read before completing

You are eligible to enroll in Platinum Blue if:

- You are enrolled in the Federal Medicare program for Part A (Hospital insurance) and Part B (Medical insurance), or Part B only. If you have Medicare Part B only, you only have coverage for Medicare Part B services. You do not have coverage for hospital, skilled nursing facilities and related services covered by Medicare Part A.
- You reside in the service area, which includes all counties in Minnesota.
- You do not have permanent End-Stage Renal Disease (ESRD) (kidney disease requiring dialysis or a kidney transplant) unless you are currently enrolled in a Blue Cross plan and you developed ESRD while a member of the plan.

Other Important Information

- If you have questions concerning your enrollment, please contact our offices:
  8 a.m. to 8 p.m. daily,
  1-877-662-2583 (**TTY** 711).
- Blue Cross determines when your enrollment form is considered complete based on Medicare enrollment guidelines.
- Your enrollment in Platinum Blue is subject to approval from CMS. If your enrollment is not approved by CMS, we will notify you immediately.
- If you choose the monthly automatic withdrawal payment option, your monthly payment will be deducted from your bank account.
- You must continue to pay your Part B Medicare premium (this premium is usually deducted from your Social Security check).
- These contracts have a minimum anticipated loss ratio of 65%. This means that on the average, you may expect that $65 of every $100 in premiums that you pay is returned to you as benefits over the life of the coverage.
- Senior LinkAge provides free health insurance information, helps explain your Medicare rights and protections, and can provide you with information about Medigap and Medicare Cost plans (like Platinum Blue). You can contact Senior LinkAge at 1-800-333-2433 and ask for a Health Insurance Counselor.

To enroll in Platinum Blue, please make sure you have completed and forwarded all necessary information to Blue Cross.

1. Carefully review and complete all sections of this form in full. Make sure you sign and date this enrollment form. Missing or incomplete information may cause a delay in the effective date of your coverage.
2. If you and your spouse wish to enroll, please complete separate enrollment forms.
3. Your requested effective date is assigned by Blue Cross unless you are just enrolling in Medicare Part B. Enrollment forms must be received by the last business day of the month in order to be effective the first day of the month following receipt of your completed form.
4. If you are just enrolling in Medicare Part B, you may apply up to three (3) months prior to your Medicare Part B effective date.
5. If the enrollee has a Durable Power of Attorney (POA), Durable POA for Health Care, or legal guardian or conservator, the legal representative may be asked to provide proof that he or she is authorized to act on the enrollee's behalf.
6. Forward the original white copy of the enrollment form to Blue Cross in the enclosed prepaid envelope and keep the pink copy for your records.

Copies: White - Blue Cross and Blue Shield of Minnesota Yellow - Sales Representative Pink - Enrollee

Individual Platinum Blue Enrollment Form
(Please Print or Type)

A Enrollee information

1. Name *Last* *First* *MI*

Gender
☐ Male ☐ Female

2. Home Address (P.O. Box is not allowed) *Street* *City* *State* *Zip*

Phone ( )

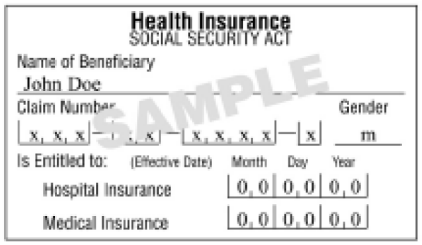
County

Billing Address (if different)

3. Birthdate

4. Marital Status
☐ Single ☐ Married ☐ Widowed

5. Medicare Information
Please provide the required information using the box on the right. You can locate the required information on your Medicare Health Insurance Card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.



Your enrollment form cannot be processed without this information.

Medicare Health Insurance
Social Security Act

Name of Beneficiary (Name of Enrollee):

_____

Medicare Claim Number:

_____

Beneficiary is Entitled to: Effective Date (MM/DD/YYYY)

_____ Hospital (Part A) _____

_____ Medical (Part B) _____

B Coverage option and payment method selection

1. Select a Medical Plan
☐ Platinum Blue Core Plan $29 per month
☐ Platinum Blue Choice Plan $74 per month
☐ Platinum Blue Complete Plan $109 per month

2. Effective date of coverage for most enrollees will be the first day of the month following receipt of completed enrollment form and confirmation of enrollment by CMS. If enrolling during the CMS annual enrollment period (October 15 - December 7), your effective date will be January 1. If you are new to Medicare Part B, you may enroll up to 90 days prior to your Part B effective date. Your Platinum Blue effective date will be the same as your Medicare Part B effective date.

3. Payment Method ☐ Monthly Automatic Withdrawal; **or** ☐ Bill me: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

C Please answer these questions. You must select "Yes" or "No" for each question below. This information is NOT used for health screening.

1.	**Have you ever been diagnosed with End-Stage Renal Disease (ESRD)?** If YES and you do not need regular dialysis, or have had a successful kidney transplant, please attach a note or records from your doctor showing that you do not need dialysis or have had a successful kidney transplant.	☐ Yes ☐ No
2.	**Do you or your spouse work?**	☐ Yes ☐ No
	If YES, do you have health coverage through your or your spouse's current or former employer? Employer name:_____ Employer address: _____ Policyholder name:_____ Policy number:_____	☐ Yes ☐ No
3.	**Are you currently enrolled in your state Medicaid program?** If YES, please provide the eight-digit Medical Assistance ID number that is on your Minnesota Health Care Programs Card: _____	☐ Yes ☐ No
4.	**Are you currently enrolled in another Medicare Advantage or Medicare Cost plan?** If YES, enrolling in Platinum Blue will cancel your membership in your current plan.	☐ Yes ☐ No
5.	**Are you now or have you ever been a Blue Cross member?** If YES, please provide your identification number. By providing your current Blue Cross identification number and signing this enrollment form, you authorize Blue Cross to coordinate cancellation of any existing Blue Cross Medicare supplement plan with the effective date of your new Platinum Blue coverage: _____	☐ Yes ☐ No
6.	**Are you using a Power of Attorney (POA), legal guardian or conservator?** If YES, please have your authorized representative sign where indicated.	☐ Yes ☐ No

D Authorization and acknowledgements

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

- Platinum Blue is a Medicare Health plan and I will need to keep my Medicare Part B while enrolled in this plan. I can be in only one Medicare Health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
- I know that I may disenroll from this Plan at any time by sending a written request to Blue Cross or by calling 1-800-MEDICARE, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Platinum Blue serves a specific service area. If I permanently move out of the service area or leave the service area for more than nine (9) consecutive months, my absence from the service area means that the plan may take action to disenroll me.
- Once I am a member of Platinum Blue, I have the right to appeal plan decisions about payment for services with which I disagree.
- I will read the Evidence of Coverage document from Blue Cross when I receive it to understand my rights, benefits and responsibilities as a member of this Medicare Cost Plan.
- I understand that beginning on the date that Platinum Blue coverage starts, in order for Platinum Blue to cover my medical services (except for emergency or urgently needed services), all of my health care must be provided or arranged by Platinum Blue. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as determined by the Medicare program. I may also be responsible for charges not covered by Medicare.

- I understand that Medicare beneficiaries are generally not covered by Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Platinum Blue and emergency services outlined in my Platinum Blue Evidence of Coverage document (also known as a member contract or subscriber agreement) are covered.
- 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 Blue Cross will send me written notification of the effective date of my enrollment in Platinum Blue.
- I acknowledge that I have been informed of the plan premium and cost-sharing amounts and that I am aware that they may be found in the Platinum Blue Evidence of Coverage.

By the signature below, I hereby authorize and request any hospital, clinic, institution, physician, or other person to furnish Blue Cross full details of diagnosis, treatment, medical history, and any other information and conclusions about me and to accept as valid a photocopy of this authorization and my signature. (We need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. We keep this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without authorization. For claims purposes, this release is valid for all claims incurred while you are enrolled in this health plan. You are entitled to receive a copy of this release.)
Release of Information: By joining this Medicare health plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

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 enrollment form means that I have read and understand the contents of this enrollment form. If signed by a legal representative (as described on page 3), 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 by Platinum Blue or Medicare.

Signature _____ Date _____

☐ I also authorize my licensed agent, identified below, to enter and transmit my enrollment form information online to Blue Cross electronically.

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

Name: _____

Address: _____

Telephone Number: (_____) _____

Relationship to Enrollee: _____

Please return the white copy in the envelope provided or by mail to: Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, Minnesota 55164-0024.

FOR AGENT USE ONLY

Agency Code MHA Agent Number 5501 Agent's Name Murray Herstein

Agent's Signature _____ Date _____

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