BlueCross BlueShield of Montana

Optional Supplemental Benefits Enrollment Form

Please contact Blue Cross and Blue Shield of Montana if you need information in another language or format (Braille).

To enroll in Optional Supplemental Benefits, please provide the following information:			
Please check the plan you want to enroll in: **(Check ONLY one)**			
Blue Cross Medicare Advantage Flex (PPO) ☐ Premier Optional Supplemental Benefits - Dental/Vision/Hearing - $60.10 per month			
LAST Name: FIRST Name: Middle Initial:			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ___/___/_____	Sex: ☐ M ☐ F	Home Phone Number: (___)___-____	Alternate Phone Number: (___)___-____
Permanent Residence Street Address:			
City:	County:	State:	ZIP Code: _____
Mailing Address (only if different from your Permanent Residence Street Address): Street Address:	City:	State:	ZIP Code: _____
Applicant Email Address:			

Please Provide Your Blue Cross and Blue Shield of Montana Insurance Information	
If you are already a Blue Cross Medicare Advantage℠ member please provide your member ID number from your insurance card.	Name (as it appears on your Member ID Card): ______ Member ID Number: ___________

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

HMO and PPO plans provided by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HMO plans available for employer/union groups only. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 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.

Applicant LAST name:	FIRST name:

Please select a premium payment option: (Select one payment option)

☐ **Get a bill**

☐ **Electronic funds transfer (EFT) from your bank account each month.**
Please enclose a VOIDED check or provide the following:

Account holder name:

Bank routing number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Bank account number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Account type: ☐ **Checking** ☐ **Savings**

☐ **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, 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.)

Please Read and Sign Below

By completing this enrollment form, I agree to add the Optional Supplemental Plan for <$XX.XX> per month, which is in addition to my monthly Blue Cross and Blue Shield of Montana plan premium.

By signing this enrollment application, I certify that I have read and understand this form and its contents. If this enrollment form is signed by an authorized individual on your behalf, it certifies that the person is authorized under state law to complete this form.

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:

Please Mail Completed Form to Address Below or Fax to:

Mail forms to:	FAX forms to:
Blue Cross Medicare Advantage **c/o Member Services** **P.O. Box 4555** **Scranton, PA 18505**	**1-855-895-4747**

Applicant LAST name: FIRST name: