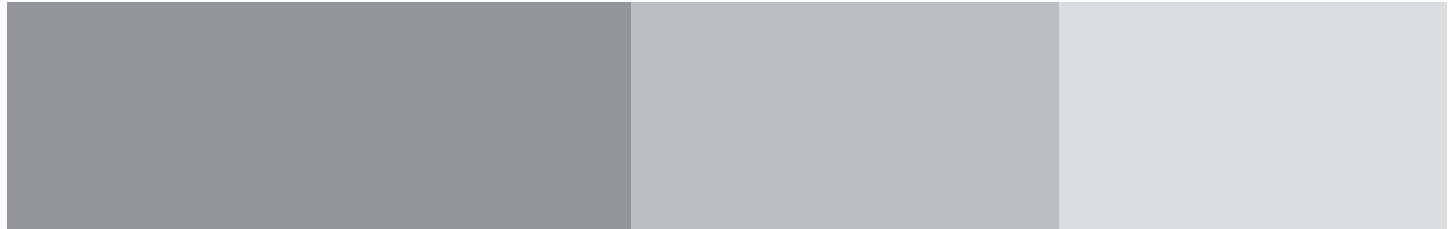


# 2025 Medicare Blue Choice<sup>®</sup> (HMO-POS) and Medicare Blue<sup>®</sup> PPO Employer/Union Group Health Plan Enrollment Request Form



Excellus BlueCross BlueShield  
Attn: Enrollment Operations  
PO Box 31790  
Rochester, NY 14603-1790

B-3687Y25 - Rochester Group

Please contact Excellus BlueCross BlueShield if you need information in another language or format (Braille).



**To Enroll in Excellus BlueCross BlueShield, Please Provide the Following Information:**

**EMPLOYER OR UNION NAME:**

Genesee Area Health Plan

**GROUP #:**

00508537

**SUBGROUP/CLASS/ENROLLMENT CODE:**

0001 / M002

**EFFECTIVE DATE (MM/DD/YYYY):**

**Please check which plan you want to enroll in:**

- Medicare Blue PPO w/o Dental (AEI)     Medicare Blue PPO **with** Dental (9J)

**LAST NAME:**

**FIRST NAME:**

**MIDDLE INITIAL:**

**BIRTH DATE (MM/DD/YYYY):**

**SEX:**

- MALE  
 FEMALE

**HOME PHONE NUMBER:**

(    )

**PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):**

**CITY:**

**COUNTY:**

**STATE:**

**ZIP CODE:**

**MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):**

**STREET ADDRESS:**

**CITY:**

**STATE:**

**ZIP CODE:**

**EMAIL ADDRESS:**

**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.

Excellus BlueCross BlueShield is an HMO plan and PPO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled to:    Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

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

**Please read and answer these important questions:**

**1** Are you the retiree?  YES  NO

If yes, retirement date (month/date/year):

If no, name of retiree:

**2** Do you or your spouse work?  YES  NO

If yes, please provide name of employer:

**3** Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Excellus BlueCross BlueShield?  YES  NO

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

Name of other coverage:

ID# for coverage:

**4** 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):

**IMPORTANT: Please read the following**

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

Excellus BlueCross BlueShield is a Medicare Advantage plan and has a contract with the Federal Government.

- I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan.
- It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
- I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
- Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.
- Excellus BlueCross BlueShield serves a specific service area. If I move out of the area that Excellus BlueCross BlueShield serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
- Once I am a member of Excellus BlueCross BlueShield, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the Evidence of Coverage document from Excellus BlueCross BlueShield when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
- I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

**IMPORTANT: Read and Sign on the Next Page:**

**IMPORTANT: Read and Sign Below:**

- I understand that beginning on the date Excellus BlueCross BlueShield coverage begins, I must get all of my health care from Excellus BlueCross BlueShield, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Excellus BlueCross BlueShield and other services contained in my Excellus BlueCross BlueShield Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR EXCELLUS BLUECROSS BLUESHIELD WILL PAY FOR THE SERVICES.**
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Excellus BlueCross BlueShield, he/she may be paid based on my enrollment in Excellus BlueCross BlueShield.
- **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 Excellus BlueCross BlueShield 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 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:**

**TODAY'S DATE:**

If you're the authorized representative, sign above and fill out these fields:

**NAME:**

**ADDRESS:**

**PHONE NUMBER:**

**RELATIONSHIP TO ENROLLEE:**

Send completed application to:

Excellus BlueCross BlueShield, Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603-1790

**Office Use Only:**

**Plan ID#:** \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP / IEP: \_\_\_\_\_ AEP / MA OEP: \_\_\_\_\_

SEP (type): \_\_\_\_\_

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

**Agent/Broker Signature:** \_\_\_\_\_ **NPN: #** \_\_\_\_\_ **Date Received:** \_\_\_\_\_

**All fields in this section are optional**

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> <b>I choose not to answer.</b>            |

What's your race? Select all that apply.

- |   |                                       |  |   |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian  | <input type="checkbox"/> Korean                    | <input type="checkbox"/> Guamanian or Chamorro          |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Vietnamese   | <input type="checkbox"/> Other Pacific Islander    | <input type="checkbox"/> Native Hawaiian                |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> White                     | <input type="checkbox"/> Samoan                         |
|   | <input type="checkbox"/> Filipino     | <input type="checkbox"/> Black or African American | <input type="checkbox"/> <b>I choose not to answer.</b> |

What is your gender? Select one.

- |                                |  |   |
|--------------------------------|--|---|
| <input type="checkbox"/> Woman | <input type="checkbox"/> Non-binary                    | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Man   | <input type="checkbox"/> I use a different term: _____ |   |

Which of the following best represents how you think of yourself? Select one.

- |  |   |
|--|---|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: _____  |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know                   |
| <input type="checkbox"/> Bisexual                              | <input type="checkbox"/> <b>I choose not to answer.</b> |

Select one if you want us to send you information in an accessible format.

- |                                  |                                      |                                   |                                  |
|----------------------------------|--------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Braille | <input type="checkbox"/> Large Print | <input type="checkbox"/> Audio CD | <input type="checkbox"/> Data CD |
|----------------------------------|--------------------------------------|-----------------------------------|----------------------------------|

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work?  Yes  No      Does your spouse work?  Yes  No

List your Primary Care Physician (PCP):

Email Address:

## Discrimination is Against the Law

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Our Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact our dedicated Medicare Customer Care representatives at 1-877-883-9577, (TTY: 1-800-662-1220). Monday - Friday, 8 a.m. - 8 p.m.  
From October 1 - March 31, 8 a.m. - 8 p.m., 7 days a week.

If you believe that our Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department  
Attn: Civil Rights Coordinator  
PO Box 4717  
Syracuse, NY 13221  
Telephone Number: 1-800-614-6575 (TTY: 1-800-662-1220)  
Fax Number: 315-671-6656

You can file a grievance in person, or by mail or fax. If you need help filing a grievance, our Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Multi-Language Insert 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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220). 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。如您需要此翻译服务，请致电 1-877-883-9577 (TTY: 1-800-662-1220)。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 1-877-883-9577 (TTY: 1-800-662-1220)。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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220). 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 quý vị cần thông dịch viên xin gọi 1-877-883-9577 (TTY: 1-800-662-1220) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-883-9577 (TTY: 1-800-662-1220). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-883-9577 (TTY: 1-800-662-1220)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220) 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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220). 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 1-877-883-9577 (TTY: 1-800-662-1220). 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。通訳をご用命になるには、1-877-883-9577 (TTY: 1-800-662-1220)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。