



**Blue Cross
Blue Shield**
of Rhode Island

City of Providence Retirees

How to Choose Your Blue Cross Medical Coverage

You have three choices for coverage:

1. BlueCHIP for Medicare Group Plus (HMO)
2. Group Plan 65 medical only and an individual Part D Prescription Drug Plan (PDP) of your choice
3. Group Plan 65 and Group Blue MedicareRx

You only need to fill out the application form(s) for the option you choose.

1. BlueCHIP for Medicare Group Plus (HMO)

Fill out *only* the BlueCHIP for Medicare application.

<p>BlueCHIP For Medicare</p>	<p>BlueCHIP for Medicare 2012 Employer Group Enrollment Request Form</p>								
<p>Please contact BlueCHIP for Medicare if you need information in another language or format (large print).</p>									
<p>To Enroll in a BlueCHIP for Medicare Employer Group Plan, Please Provide the Following Information:</p>									
Employer or Union Name: _____		Group #: _____							
<p>Please check which plan you want to enroll in:</p> <p><input type="checkbox"/> BlueCHIP for Medicare Group Plus (HMO) <input type="checkbox"/> BlueCHIP for Medicare Group Preferred Unlimited (HMO-POS)</p> <p><input type="checkbox"/> BlueCHIP for Medicare Group Preferred (HMO-POS)</p>									
LAST Name: _____	FIRST Name: _____	Middle Initial: _____ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.							
Birth Date: _____ (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: _____ (____) _____-____							
Alternate Phone Number: _____ (____) _____-____									
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: _____							
Primary Language Spoken: _____									
E-mail Address: (providing this information is optional) _____									
Please Provide Your Medicare Insurance Information:									
<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card <p>--OR--</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">SAMPLE ONLY</td> </tr> <tr> <td>Name: _____</td> </tr> <tr> <td>Medicare Claim Number: _____ Sex: _____</td> </tr> <tr> <td>Is Entitled To _____ Effective Date _____</td> </tr> <tr> <td>HOSPITAL (Part A) _____</td> </tr> <tr> <td>MEDICAL (Part B) _____</td> </tr> </table>		SAMPLE ONLY	Name: _____	Medicare Claim Number: _____ Sex: _____	Is Entitled To _____ Effective Date _____	HOSPITAL (Part A) _____	MEDICAL (Part B) _____
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Name: _____									
Medicare Claim Number: _____ Sex: _____									
Is Entitled To _____ Effective Date _____									
HOSPITAL (Part A) _____									
MEDICAL (Part B) _____									
Please Read and Answer These Important Questions:									
<p>1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, retirement date (month/date/year): _____ If no, name of retiree: _____</p>									
<p>2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ Name of dependents: _____</p>									
<p>3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>									

2. Group Plan 65 medical only *and* an individual Part D Prescription Drug Plan (PDP) of your choice

Fill out *only* the Plan 65 application. Apply separately for the PDP of your choice.

Plan65[®] <small>Medicare Supplement</small>		Group Plan 65 Member Application for Health Insurance															
<p>Please be sure ALL information below is complete to avoid delays in processing. Please print clearly using blue or black ink.</p>																	
Section 1 Employer Information (To be completed by plan administrator)																	
Group name		Group number		Dept. number													
Section 2 Applicant Information																	
Last name		Suffix	First name		M.I.												
Home address (street/apartment number)			City/town	State	ZIP code												
Mailing address (if different){street/apartment number, city/town, state, ZIP code}																	
Date of birth (mm/dd/yyyy)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)	Current BCBSRI ID number (if applicable)													
Home phone number			Cell phone number														
What is your primary language spoken?																	
What was the name of your prior health insurance carrier?			What was the date of termination? (mm/dd/yyyy)														
<p>_____</p>			<p>_____</p>														
<p>Please attach a copy of certificate of creditable coverage showing coverage end date. Application will not be processed until received.</p>																	
If you have Original Medicare, please provide your beneficiary information, Medicare claim number and effective dates below.																	
Medicare Claim Number Medicare Hospital Insurance (Part A) Effective Date: Month/Day/Year Medicare Medical Insurance (Part B) Effective Date: Month/Day/Year		<table border="1"> <tr> <th colspan="2">Health Insurance and Social Security Act</th> </tr> <tr> <td colspan="2">Name of beneficiary:</td> </tr> <tr> <td colspan="2">Medicare claim number:</td> </tr> <tr> <td colspan="2">Effective dates:</td> </tr> <tr> <td>Part A (hospital)</td> <td>___/___/___</td> </tr> <tr> <td>Part B (medical)</td> <td>___/___/___</td> </tr> </table>				Health Insurance and Social Security Act		Name of beneficiary:		Medicare claim number:		Effective dates:		Part A (hospital)	___/___/___	Part B (medical)	___/___/___
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Name of beneficiary:																	
Medicare claim number:																	
Effective dates:																	
Part A (hospital)	___/___/___																
Part B (medical)	___/___/___																
GPL65APP (7-10)		continued ►															

3. Group Plan 65 medical *and* Group Blue MedicareRx

Fill out *both* the Plan 65 application and Blue MedicareRx applications.

Plan 65[®] Medicare Supplement		Group Plan 65 Member Application for Health Insurance															
<p>Please be sure ALL information below is complete to avoid delays in processing. Please print clearly using blue or black ink.</p>																	
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Group name		Group number		Dept. number													
Section 2 - Applicant Information																	
Last name		Suffix	First name		M.I.												
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Mailing address (if different)(street/apartment number, city/town, state, ZIP code)																	
Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (XXX-XX-XXXX)		Current BCBSRI ID number (if applicable)													
Home phone number			Cell phone number														
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Part A (hospital)	___/___/___																
Part B (medical)	___/___/___																
Medicare Hospital Insurance (Part A) Effective Date: Month/Day/Year																	
Medicare Medical Insurance (Part B) Effective Date: Month/Day/Year																	

Official Use Only: Data Stamp



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**Blue MedicareRxSM (PDP)
Medicare Prescription Drug Plan
2012 Enrollment Form**

Form completed applications to your Employer

Please refer to the Blue MedicareRx (PDP) Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx plans. The joint enterprise is a Medicare-approved Part D Sponsor.

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**Blue Cross
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of Rhode Island

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