



BC Life & Health Insurance Company

Freedom Blue PPOSM Enrollment Form

Please type or print in ink. This plan is available in limited areas. We cannot consider this enrollment form complete until we have obtained your Medicare information. Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card or your letter of verification from the Social Security Administration or Railroad Retirement Board.

Please fill in these blanks so they match your Medicare card

Name of Beneficiary	Is Entitled to:	Medicare Effective Date:
Medicare Claim Number (including alpha letter)	Sex	
	Part A Hospital Insurance	____ / ____ / ____
	Part B Medical Insurance	____ / ____ / ____

1. Applicant Information: Applicant must complete this section.

Application for Freedom Blue PPO (Select One):	<input type="checkbox"/> Plan I	<input type="checkbox"/> Plan II
Name (exactly as it appears on Medicare Card)	Social Security Number (optional)	
Permanent Residence Address, Apt.# (required)	City	County State Zip
Billing Address (If different from permanent residence)	City	County State Zip
PO Box	City	County State Zip
Home Phone Number ()	E-mail Address (optional)	Date of Birth: Month/Day/Year
Emergency Contact (relative or friend)	Phone Number ()	Relationship to you
If converting from a BC Life & Health Group or Individual Plan, indicate which plan		
Name of Employer (if a Group Plan) or Individual Plan	City	State Zip
Group or Certificate Number	Termination Date	

A. I am currently enrolled in a Medicare Advantage plan. Yes No

If yes, your enrollment in Freedom Blue will automatically cancel your membership in your current Medicare Advantage plan. You cannot be a member of two Medicare Advantage plans at the same time.

Optional: If question A is yes, please provide name of other Medicare Advantage plan:

B. If you are enrolling in a plan with a monthly premium, how would you like to pay future plan premiums?

You can have the monthly premium for this Medicare Advantage plan automatically deducted from your Social Security check. If you don't choose this option, you can choose to have your monthly premium automatically deducted from your checking account or to receive a bill from us each month, which you can pay by mail. Generally you must stay with the option you choose for the rest of the year.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. However, because you might be responsible for paying a portion of your plan's monthly premium, you must choose one of the payment options below.

Please choose one of the following payment options:

- I would like to deduct from my Social Security Administration benefit check.
- I would like to deduct from my checking account
(complete "Optional Monthly Checking Account Deduction Authorization" form to page 4).
- I would like to receive a premium bill and mail my check to Freedom Blue each month.

C. Effective date of coverage will normally be the first of the month following receipt of the completed application. Please note: Individuals newly eligible for Medicare may apply up to three months prior to their eligibility date for Medicare. Their enrollment date will be the same date as their Medicare effective date.

Individuals submitting an application during the Annual Open Enrollment in November must choose an enrollment effective date: December January

2. Health Information

A. Do you have End-Stage Renal Disease (ESRD) or receive routine kidney dialysis treatment? Yes No

If you have ESRD or have not yet had a successful kidney transplant, you cannot enroll in Freedom Blue unless you are already enrolled as a member of any BC Life & Health Plan, or if you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing that you don't need dialysis or have had a successful kidney transplant.

Your answers to the following health information questions will not affect your eligibility to enroll in Freedom Blue.

B. Are you currently eligible for MediCal? Yes No
(California state assistance through the Department of Health Services)

If yes: MediCal number:

C. Are you currently a resident in a Medicare certified institution (such as a skilled nursing facility, rehabilitation hospital, etc.)? Yes No

If yes: Name _____ Address _____ City _____ State _____ Zip _____
Institution Phone # _____ Date of Admission into Institution _____

D. Do you or your spouse work? Yes No

2. Health Information (cont.)

- E. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Freedom Blue? Yes No

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

Name of other coverage	ID # for this coverage	Group # for this coverage
_____	_____	_____
_____	_____	_____

- F. Do you, either on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' compensation, or VA benefits? Yes No

If yes: What kind of health insurance do you have? _____

Name of Insurance Carrier _____

Employer Name _____

Other Carrier's Address (City, State, Zip) _____

Policyholder Name _____ Policy Number _____

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Freedom Blue could affect your employer or union health benefits or may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

3. "Lock-In" Agreement and Requirements

I understand that I, as a member of Freedom Blue, beginning on the effective date of my coverage, must receive all of my health care from contracted providers with the exception of emergency or urgently needed services or for out-of-area-renal dialysis. The use of non-plan providers is allowed, but may cost more. I understand that services authorized by Freedom Blue and all other services detailed in my Evidence of Coverage/Member Services Guide will be covered under my Freedom Blue plan. I also understand that without authorization, neither Freedom Blue nor Medicare will pay for these services.

I understand that all plan benefits, conditions, limitations and exclusions of coverage are detailed in the Freedom Blue Evidence of Coverage/Member Services Guide, which is given to me when I become a member.

Initial: _____

4. Please Read and Sign Below

I understand that the effective date of coverage referenced in Section 1 of this application, is when I can begin using Freedom Blue services, and that BC Life & Health will send me written notification of the effective date of my enrollment in Freedom Blue, usually the 1st of the month after receipt by BC Life & Health. I understand that I should not cancel or drop any supplemental insurance I currently have until I receive written notice of my actual effective date from BC Life & Health.

I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable.

I understand that I can be a member of only one Medicare Advantage plan at a time, and that by enrolling in Freedom Blue, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage plan of which I am currently a member.

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

I understand that it is my responsibility to inform BC Life & Health prior to a permanent move out of the Freedom Blue service area or leaving the Freedom Blue service area for a temporary move of more than six months. My absence, under these two conditions means that BC Life & Health may take action to disenroll me from Freedom Blue and return me to traditional Medicare for medical coverage.

I understand that enrollment in this plan is generally for the entire year. I may disenroll from Freedom Blue only at certain times of the year, or under certain circumstances, by sending a written request to Freedom Blue Member Services, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048). I understand that I must continue to receive all my health care from Freedom Blue providers until BC Life & Health informs me of the effective date of disenrollment.

I understand that as a member of Freedom Blue, I have the right to ask about the plan's decision about payment or services if I disagree. Once I am a member of Freedom Blue, I have the right to appeal plan decisions about payment or services if I disagree.

I further understand and acknowledge the selling agent has no authority to promise me coverage or to modify BC Life & Health underwriting policy or terms of any BC Life & Health coverage.

I understand that plan benefits, conditions, limitations and exclusions of coverage are detailed in the Freedom Blue Evidence of Coverage/Member Services Guide, which is given to me when I become a member.

I acknowledge that I have read and understand the Freedom Blue outpatient prescription drug benefit as described in the Freedom Blue Summary of Benefits, a copy of which has been provided to me. I am aware that only those prescription drugs included in the Freedom Blue approved Formulary list will be covered under the plan.

I understand that BC Life & Health requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 requires specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

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4. Please Read and Sign Below (cont.)

I have personally read and completed this application. I understand that receipt of money with this Enrollment form does not create Freedom Blue Coverage. Coverage will come into effect only if this application is approved by BC Life & Health. I, the applicant, acknowledge that I have read and understand the Enrollment form and the accompanying marketing materials in their entirety. If signed by a person authorized to act on my behalf, 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 by Freedom Blue or by Medicare.

x _____

Applicant's Signature
(or signature of Legal Guardian or GDPA)

x _____

Date of Signature

Please refer to the Freedom blue Evidence of Coverage/Member Services Guide for a complete listing of all plan benefits, conditions, limitations and exclusions of coverage.

Agent Only

- 1) I have reviewed with the applicant and given to them a copy of the Summary of Benefits for the policy applied for. I additionally certify that the applicant is entitled to Part A and enrolled in Part B of Medicare.
2. I have assisted the applicant in filling out this application. Yes No

Agent's Signature _____ Date _____

Print Agent's Name _____ Agent Number _____

Appointment Set By (TM#) _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip _____

Amount Paid w/App. \$ _____

If the plan you are applying for has a monthly premium, *please enclose a check payable to BC Life & Health for one month's premium in the pocket attached to page 4. Insert signed, dated check face up.*

Blue Cross Use Only

Group # _____ Effective Date of Coverage _____

ICEP _____ AEP _____ SEP (type) _____ OEP _____

Plan Rep. Initials _____ Agent Number _____

Applicant: Please return the completed enrollment form to your agent or to:

Freedom Blue
P.O. Box 9154
Oxnard, CA 93031-9154



Freedom Blue is a RPPO with a Medicare Advantage contract. Anyone with Medicare may apply. You must be entitled to Part A and be enrolled in Part B, and continue to pay your Medicare Part B premiums. Copayments, restrictions, and limitations may apply. Benefits are subject to change annually upon contract renewal with the Medicare program.



As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BC Life & Health provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize BC Life & Health to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my BC Life & Health dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Subscriber _____

Social Security Number _____

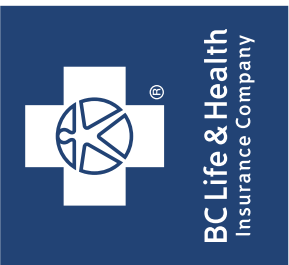
Group Number _____

Bank Name _____

X _____ Date _____

X _____ Date _____

Authorized Signature(s) as it/they appear in the financial institution's records; all authorized persons must sign.



Senior Services Toll-Free Number

1-877-811-3107 (TTY: 1-888-877-5378)

Monday – Thursday 8:00 a.m. to 6:00 p.m., Friday 8:00 a.m. to 3:00 p.m.

IF YOU HAVE A MONTHLY PLAN PREMIUM, PLEASE ENCLOSE IT IN THIS POCKET.
If you wish to enroll in the Optional Monthly Checking Account Deduction Authorization Program, please complete the form on the other side. Include a blank check marked VOID. A deposit slip is not acceptable.