2025 Individual Enrollment Request Form

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:
- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:
- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?
You can join a plan:
- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans
- Dual eligibles are allowed enrollment once per month into a FIDE SNP, AIP, or Original Medicare with a PDP. Enrollment is effective the first of the following month.

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?
- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:
- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?
Email, mail, or fax your completed and signed form to:

Email: WHMembership@blueshieldca.com
Mail: Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856
Fax: (877) 251-3660

Once they process your request to join, they'll contact you.

How do I get help with this form?
Call your authorized agent or your Blue Shield representative at **(888) 534-4263**. TTY users can call **711**. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llame a su Agente Autorizado o a su Representante de Blue Shield al **(888) 534-4263**. Los usuarios del sistema TTY pueden llamar al **711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness
- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

Blue Shield TotalDual Plan (HMO D-SNP)

☐ Los Angeles/San Diego Counties
($0 per month)

Last name:	First name:	Middle initial: (optional)
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	
Phone number:	Phone type: ☐ Landline ☐ Mobile	

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):

Street Address:

City: State: ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street Address:

City: State: ZIP code:

Your Medicare information:

Medicare number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Shield TotalDual Plan? ☐ Yes ☐ No

Prescription drug coverage:

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Medical coverage:

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Are you enrolled in your state Medicaid (Medi-Cal) program? ☐ Yes ☐ No
If yes, please provide your Medicaid (Medi-Cal) number (required):

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Shield TotalDual Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Blue Shield TotalDual Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when Blue Shield TotalDual Plan coverage begins, I must get all of my medical and prescription drug benefits from Blue Shield TotalDual Plan. Benefits and services provided by Blue Shield TotalDual Plan and contained in my Blue Shield TotalDual Plan *Evidence of Coverage* (EOC) document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Shield TotalDual Plan will pay for benefits or services that are not 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 my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Signature:	**Today's date (MM/DD/YYYY):**

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

Name:

Street address:

City: State: ZIP code:

Phone number:

Relationship to enrollee:

Section 2 – 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.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender?

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? (select one)

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Select one if you want us to send you information in a language other than English.

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Chinese (Simplified)
- ☐ Chinese (Traditional)
- ☐ Farsi
- ☐ Korean
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Customer Service at **(800) 452-4413 (TTY: 711)** if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week.

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

List your primary care physician (PCP), clinic, or health center:

Physician, clinic, or health center name:

Physician, clinic, or health center ID #:

Physician, clinic, or health center group name:

Current patient? ☐ Yes ☐ No

Email address:	**Mobile phone number:**

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or **you can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

To learn more about your payment options, visit us at **blueshieldca.com/medicarewaystopay** or call Customer Service at **(800) 452-4413 (TTY: 711)**.

☐ 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/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Shield of California the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. SHIP counselors, family members, or other third parties) helping the enrollee fill out this form.

Name: _____

Signature: _____

Relationship to enrollee:

☐ SHIP Counselors ☐ Authorized representative

☐ Other (third party) ☐ Self

Producer/Writing Agent information:

*Indicates required field.

Appointed agency name: _____

(please print appointed agency name)

Appointed agency's Tax ID*: _____

(please print appointed agency's tax ID)

Producer/Writing Agent's name*: _____

(please print producer/writing agent's name)

Producer/Writing Agent's individual NPN*: _____

(please print producer/writing agent's individual NPN)

Producer/Writing Agent's phone number: _____

Producer/Writing Agent's email address: _____

Date application received by producer/writing agent: _____

Producer/Writing Agent's signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is an HMO D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.

Privacy Act Statement

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

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date MM/DD/YYYY)

  _____.
- ☐ I recently was released from incarceration. I was released on (insert date MM/DD/YYYY)

  _____
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date MM/DD/YYYY)

  _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date MM/DD/YYYY)

  _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date MM/DD/YYYY)

  _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date MM/DD/YYYY)

  _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date MM/DD/YYYY)

  _____.

☐ I recently left a PACE program on (insert date MM/DD/YYYY)

_____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date MM/DD/YYYY)

_____.

☐ I am leaving employer or union coverage on (insert date MM/DD/YYYY)

_____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date MM/DD/YYYY)

_____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in the plan. I was disenrolled from the SNP on (insert date MM/DD/YYYY)

_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

- ☐ I missed Initial Election Period (IEP)
- ☐ I missed Annual Enrollment Period (AEP)

☐ I'm in a plan that was recently taken over by the state or territorial regulatory authority because of financial issues. I want to switch to another plan.

☐ I'm in a plan that had a star-rating less than 3 stars for the last 3 years. I want to join a plan with a star rating 3 stars or higher.

☐ I am new to Medicare AND Medicare entitlement was made retroactively so I was notified about getting Medicare after my Part A and/or B effective date.

If none of these statements applies to you or you're not sure, please contact Blue Shield of California at **(888) 534-4263 (TTY: 711)** or Authorized Agent, to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.