MASSACHUSETTS

2025

MEDICARE HMO BLUE (HMO)

To complete your group enrollment form:

Be sure to complete all information, sign, and date your enrollment form. Return the completed form(s) to your employer. We'll contact you in writing when we receive your enrollment form, and notify you of your effective date of coverage.

WHO CAN USE THIS FORM?

People with Medicare who want to join a Medicare Advantage plan supported by their prior employer, also referred to as retiree coverage.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the United States
- 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 will receive this form from your prior employer to enroll in the retiree coverage.

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:

Your prior employer will be invoiced for this Medicare Advantage plan coverage.

WHAT HAPPENS NEXT?

Send your completed and signed form to your prior employer that is offering you retiree coverage.

OMB No. 0938-1378 Expires: 6/30/2026

2025 Blue Cross Medicare Advantage Medicare HMO Blue (HMO) Employer Group Enrollment Form

Employer Group Received Date

Employer use only:

Group name: Group number: Requested eff date:

Section 1 — Member Use — All fields are required (unless marked optional).

First name: Last name: Middle initial (optional):

Birth date: (MM/DD/YYYY) (__ __ __ __ __ __ __ __) Sex: ☐ Male ☐ Female Phone number: ( ) - County (optional):

Permanent residence (don't enter a P. O. Box):

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: ____ ____ ____ ____ - ____ ____ ____ -____ ____ ____ ____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Medicare HMO Blue (the Plan).
- By joining this Medicare Advantage Plan, I acknowledge that the 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 on the next page).
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the United States border.
- I understand that when the Plan coverage begins, I must get all my medical and prescription drug benefits from the Plan. Benefits and services provided by the Plan and contained in the Plan (Evidence of Coverage) document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor the Plan will pay for benefits or services that are not covered.
- 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:

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

Name: Address:

Phone number: Relationship to enrollee:

(Continued)

Section 2 – All fields below 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 of Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or of Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or of 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
- ☐ Black or African American
- ☐ White

Asian:

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

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ **I choose not to answer.**

What is your gender? Select one.

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

☐ Check here if you want us to send you information in a language other than English.
Language:_____

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

- ☐ Large print
- ☐ Braille
- ☐ Audio CD
- ☐ Data CD

If you need information in an accessible format other than what's listed above, please call us at **1-800-200-4255**. We're open 8:00 a.m. to 8:00 p.m. ET, Monday-Friday, from April 1 to September 30; and 8:00 a.m. to 8:00 p.m. ET, seven days a week, from October 1 to March 31. TTY users can call **711**.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

I would like to receive materials via email: ☐ Yes ☐ No Email address:

Answer these important questions:

Will you have prescription drug coverage (like VA, TRICARE®) in addition to this Plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

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.

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 the first page of this document to send your completed form to the plan.