

# MEDICARE PPO BLUE (PPO)

## 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.

## 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'll 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.

## INDIVIDUALS EXPERIENCING HOMELESSNESS

If you want to join this plan but have no permanent residence, a P.O. 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.



## WHAT HAPPENS NEXT?

**Return completed form to your employer. We'll contact you in writing when we receive your enrollment form, and notify you of your effective date of coverage.**

**2026 Blue Cross Medicare Advantage  
Medicare PPO Blue (PPO)  
Employer Group Enrollment Form**

Employer Group Received Date

**Employer use only:**

Group name: **Town of Chelmsford**      Group number: **6648607**      Requested effective date:

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

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle name (optional): \_\_\_\_\_

Birth date: (MM/DD/YYYY) (\_\_\_\_\_) Sex:  Male  Female Phone number: ( ) -

Permanent residence street address (Don't enter a P. O. Box):

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ County (optional): \_\_\_\_\_

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 PPO 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). 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 or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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: \_\_\_\_\_

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

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_

(Continued)

## 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:

## 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.

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

- Spanish  Chinese Mandarin  Chinese Cantonese  French  Vietnamese  
 Korean  Russian  Arabic

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

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

## 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 submit your completed form.

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

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