

Group Name _____
 Group # _____
 HCFA # _____
 Effective Date _____
 Disenroll Date _____



I understand that neither Medicare nor Keystone will pay for services if they are not provided by a plan physician or arranged for by a plan physician and approved by Keystone in advance, except in emergency or urgent cases.

GROUP ENROLLMENT APPLICATION/CHANGE FORM

A Keystone 65 enrollment information—Your Primary Care Physician selection must be made from the Keystone 65 Physician Directory.

Would you prefer us to send you information in a language other than English? If yes, language _____

Please PRINT your name and address below:
 Name _____
 Address _____
 City _____ State _____ Zip _____

Social Security No.: □□□-□□-□□□□
 County: _____ Home Phone: (____) _____
 Date of Birth: _____ Sex: Male Female

Past Employer _____ Present Marital Status
 Single Separated Married Widowed Divorced

Primary Dental Office Name & Provider #				E-Mail Address		
Last Name, First, M.I.	Date of Birth	Sex	Social Security Number	Primary Care Physician Name If Current Physician Check Box	✓	Physician Code Number
Subscriber						
Spouse						
Child						

B Requested Action – Please print clearly

ADDITIONS	CHANGES	TERMINATION
<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Name	<input type="checkbox"/> Termination
<input type="checkbox"/> Enroll me in Keystone 65	<input type="checkbox"/> Address	<input type="checkbox"/> From Plan
<input type="checkbox"/> Add Spouse		
<input type="checkbox"/> Enroll my spouse in Keystone 65		
Desired effective date ____/____/____		

C Please answer the following questions:

Are you...	Subscriber		Spouse	
* Medicaid eligible? If yes, give Medicaid # _____	Yes	No	Yes	No
* Residing in a Nursing Home or Foster Care Home?	Yes	No	Yes	No
* Converting from other Keystone coverage? <i>You cannot be denied enrollment if you answer yes to any of the above questions.</i>	Yes	No	Yes	No
* Suffering from End-Stage Renal Disease? (Kidney disease or transplant)	Yes	No	Yes	No

D Other insurance

Current Health Insurance (check one) Blue Cross/Blue Shield
 AARP Aetna/U.S. Healthcare Keystone Health Plan East
 Security 65 Healthnet Other Personal Choice
 Are you or your spouse employed? Yes No
 Name of company/ies: _____
 Do you have a PACE card? Yes No

E Emergency information

Please print the name and telephone number of the closest relative or friend to be contacted in case of emergency.

Name _____ Telephone _____

F Copy this information directly from your Medicare card

SUBSCRIBER INFORMATION

Health Insurance

CLAIM NUMBER SOCIAL SECURITY ACT
 □□□ - □□ - □□□□ - □

IS ENTITLED TO EFFECTIVE DATE
 HOSPITAL INSURANCE PART A □□ - □ - □□
 MEDICAL INSURANCE PART B □□ - □ - □□

SPOUSE INFORMATION

Health Insurance

CLAIM NUMBER SOCIAL SECURITY ACT
 □□□ - □□ - □□□□ - □

IS ENTITLED TO EFFECTIVE DATE
 HOSPITAL INSURANCE PART A □□ - □ - □□
 MEDICAL INSURANCE PART B □□ - □ - □□

G Important: Read back of Enrollment Form and sign below.

Signature (Beneficiary or authorized representative)† X _____ Date _____
 Signature (spouse Beneficiary or authorized representative)† X _____ Date _____
 †Authorized representative must provide supporting documentation; for example, copy of durable power of attorney papers.
 Employer Signature _____ Date _____ If anyone helped you fill out this form, he or she must sign the following line:
 Signature _____ Date _____ Relationship to Beneficiary _____

Please keep the gold copy of this enrollment form as temporary ID, valid for 90 days from enrollment date.

I UNDERSTAND THAT THE FOLLOWING STATEMENTS ARE A PART OF MY CONTRACT WITH KEYSTONE HEALTH PLAN EAST.

1. I understand that Medigap insurance or other supplemental insurance is no longer necessary because Keystone 65 pays the deductibles and coinsurance usually paid by Medigap. However, I understand that I may either keep my current policy or cancel it if I am satisfied with Keystone 65. I also understand that I will generally not need a Medigap policy if I enroll in a Medicare contracting health plan; however, a Medigap policy could be of value to me if I leave Keystone 65 and return to Fee-For-Service Medicare.
2. By enrolling in a Medicare+Choice plan, I hereby authorize the Health Care Financing Administration (HCFA) to provide information to Keystone Health Plan East confirming my entitlement to Hospital Insurance Benefits (Part A) and to any supplementary Medical Insurance Benefits (Part B) under Title XVIII (The Medicare Program) of the Social Security Act.
3. I hereby authorize Keystone Health Plan East and its contracted providers, who hold medical or other relevant information about myself, to release to HCFA or HCFA's agents information needed to administer Title XVIII of the Social Security Act.
4. I understand that I am required to select a personal physician from the Keystone Health Plan East Keystone 65 physician directory and that I am required to have my physician provide or arrange for all the medical services I need. I understand that, except for emergencies and urgently needed care, unauthorized services received will not be covered.
5. I understand that it is my responsibility to inform Keystone Health Plan East prior to moving or leaving the service area for more than 6 months, and that my absence means that Keystone Health Plan East may take action to disenroll me from Keystone 65 and return me to traditional Medicare coverage.
6. I authorize Keystone Health Plan East to obtain from my providers of service and hospitals, the medical records relating to the administration of my contract with Keystone Health Plan East.
7. I understand that the benefits I will be eligible for in the Keystone Health Plan East Keystone 65 Member Handbook and the Keystone Health Plan East marketing materials are only a summary. A full explanation of my benefits are detailed in the Member Evidence of Coverage.
8. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my application, or disenrollment.
9. I understand that I may disenroll from Keystone 65 by sending a written request to Keystone 65, the Social Security Office, or the Railroad Retirement Board. Until the effective date of disenrollment, I must continue to receive health care from Keystone 65 contracted providers.
10. I understand that I may cancel my enrollment in Keystone 65 at any time. If I decide to cancel my enrollment, my unused premium, if any, will be refunded. I understand that my termination will become effective the first month following receipt of my written request by Keystone Health Plan East. Until the effective date of disenrollment, I must continue to receive health care from Keystone 65 contracted providers.
11. If I select the Point of Service option, I am required to select a Primary Care Physician, and receive all routine and Preventive Care from my Primary Care Physician.
12. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using Keystone 65 plan services, Keystone 65 will still be sending me final confirmation of my enrollment. I understand that I should not disenroll from any Medicare supplemental plan or Medigap/Medicare Select plan until I receive confirmation of my enrollment from Keystone 65.
13. I warrant that the information on this form is true, correct and complete.
14. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
15. I understand that I can be a member of only one Medicare+Choice plan at a time. By enrolling in Keystone 65, I will automatically be disenrolled from any other Medicare+Choice plan of which I am currently a member. I also understand that since I can be a member of only one Medicare+Choice plan at a time, I cannot enroll in more than one Medicare+Choice plan with the same effective date of coverage. If I do this, my enrollment will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare+Choice plan.
16. I understand 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.
17. I understand that as a member of Keystone 65, I have the right to appeal service and payment denials made by the plan.
18. If I am unable to sign, (1) a court-appointed Legal Guardian or (2) person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign the application. A copy of the proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by state law must be attached.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.