



EMPLOYER GROUP APPLICATION/CHANGE FORM

Easy step-by-step instructions for filling out this
Keystone 65 HMO enrollment form.

SECTION A

Personal Information — Provide the personal information requested. Then check the box(es) in front of your requested action and provide information about your employer or union.

SECTION B

Medicare Insurance Information — Use your Medicare card to complete this section.

SECTION C

Important Questions — Please answer the questions in this section.

SECTION D

Choose Your Providers — Please select a Primary Care Physician (from the *Keystone 65 HMO* Doctor and Hospital Directory) and a Primary Dental Office (from the Dental Provider Directory).

SECTION E

Your Signature — Please read the information provided, then sign and date your enrollment form. If you are an authorized representative, please provide the information requested.

QUESTIONS?

Call toll-free **1-877-393-6733**

TTY users should call toll-free **1-877-219-5457**

Seven days a week, 8 a.m. to 8 p.m.

www.site65.com

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.

Agent/Broker Name: _____

A To enroll in Keystone 65 HMO, please provide the following information:

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: MM-DD-YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: - - - - -
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Permanent Residence Street Address:

City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency Contact: _____

Phone Number: - - - - - Relationship to You:

E-mail Address:

Requested Action:	ADDITIONS	CHANGES	TERMINATION
	<input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Spouse	<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Other	<input type="checkbox"/> Termination from plan

Past Employer/Union:
Name of Employer/Union (Past or Present): _____


Group #: - - - - - Desired Effective Date: MM-DD-YYYY

B Please provide your Medicare insurance information

Please take out your Medicare Card to complete this section.

- Please fill in the blanks so they match your red, white, and blue Medicare card
- OR –
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

	
SAMPLE ONLY	
Name: _____	Sex _____
Medicare Claim Number - - - - -	
Is Entitled To	Effective Date
HOSPITAL (Part A)	- - - - -
MEDICAL (Part B)	- - - - -

C Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered “yes” to this question and 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 you do not need dialysis or have had a successful kidney transplant.

2. Do you currently have health insurance? 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: _____

3. 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 *Keystone 65 HMO*? 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: _____

4. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If “yes”, please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

5. Are you enrolled in your State Medicaid program? Yes No

If “yes”, please provide your Medicaid number: _____

6. Do you or your spouse work? Yes No

D Please choose your providers

Primary Care Physician (check box if current physician)

Physician Code No.

The 10-digit number beneath provider name in directory

Primary Dental Office Name

Primary Dental Provider No.

The 10-digit number beneath provider name in directory

Please read and sign below

By completing this enrollment application, I agree to the following:

Keystone 65 HMO is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan by sending a request to Keystone 65 HMO or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week.

Keystone 65 HMO serves a specific service area. If I move out of the area that Keystone 65 HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Keystone 65 HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Keystone 65 HMO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that — depending on my employer/union coverage — Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Keystone 65 HMO coverage begins, I must get all of my health care from Keystone 65 HMO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Keystone 65 HMO and other services contained in my Keystone 65 HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KEYSTONE 65 HMO WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Keystone 65 HMO will release my information including any prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 Keystone 65 HMO or by Medicare.

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Your Signature:

Today's Date:

MM-DD-YYYY

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: □□□-□□□-□□□□

Relationship to Enrollee: _____

Office Use Only

Name of staff member (if assisted in enrollment): _____

Group #: _____ Group Name: _____

Desired Effective Date of Coverage: _____ Disenroll Date: _____