MEDICARE HEALTH PLAN SWITCH ENROLLMENT FORM

A RETIREE INFORMATION

Social Security No.	Last Name First Name

B APPLICANT INFORMATION

Social Security No.	Last Name First Name	Date of Birth (MM/DD/YYYY)
Relationship to Retiree	Physical Address	
Effective Date of Change	City State Zip Code	

C MEDICARE INFORMATION

1) Please take out your Medicare card to complete this section:

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR –

- Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.

2) Do you have End-Stage Renal Disease (ESRD) ☐ **Yes** ☐ **No**
-If yes, please contact the NMRHCA at 1-800-233-2576 for further instructions

3) Do you plan to reject Medicare Part B? ☐ **Yes**** ☐ **No**

MEDICARE HEALTH INSURANCE

Name: _____

Medicare Claim Number Sex

__ __ __ __ - __ __ __ - __ __ __ __ M F

Is Entitled To Effective Date

HOSPITAL (Part A)* __ / __ /____

MEDICAL (Part B)** __ / __ /____
M M D D Y Y Y Y

4) Are you enrolled under private insurance, TRICARE, Federal employee health benefits, VA Benefits, or State Pharmaceutical Assistance Programs? ☐ **Yes** ☐ **No**

5) Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

*** If you do not have Part A, written notice is required from Social Security indicating why you are not eligible for Medicare Part A. ** Although Medicare allows you to reject Part B, you are <u>required</u> to purchase it in order to enroll in any NMRHCA Medicare Plan.**

D SELECTION OF MEDICAL PLAN (check one)

❑ BCBSNM Medicare Supplement Plan	**Medicare Parts A and B required.**
❑ BCBSNM Advantage Plan I ❑ BCBSNM Advantage Plan II	IMPORTANT: If you are switching to a BCBS Advantage Plan service area is limited to New Mexico. **Medicare Parts A and B required.**
❑ Presbyterian Advantage Plan I ❑ Presbyterian Advantage Plan II	IMPORTANT: If you are switching to a Presbyterian Advantage Plan service area is limited to New Mexico. **Medicare Parts A and B required.**
❑ United Healthcare Advantage Plan I ❑ United Healthcare Advantage Plan II	**Medicare Parts A and B required. Physical address necessary.**
❑ Humana Advantage Plan I ❑ Humana Advantage Plan II	**Medicare Parts A and B required. Physical address necessary.**

E DECLARATION AND SIGNATURE

I hereby declare that I understand the consequences of not carrying **Medicare Part B** and that the information I have provided above is true and complete to the best of my knowledge. I understand that my premiums may be adjusted to reflect the changes I have requested on this form and they may be adjusted from time to time, and I authorize that adjustment in my pension deduction or bank draft unless I cancel Coverage. I understand that I may be direct-billed and should pay the billed amount directly until any change in my deduction or draft amount is processed. I authorize representatives of the NMRHCA and/or the medical insurance carrier I selected above to obtain information from the Social Security Administration regarding my and/or my dependent(s) Medicare eligibility. *(If signing under power of attorney, please attach authorizing documents.)*

Retiree _____ **Date**_____

Spouse _____ **Date**_____