

MEDICARE HEALTH PLAN SWITCH ENROLLMENT FORM

A**RETIREE INFORMATION**

Social Security No.	Last Name	First Name
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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

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 required to purchase it in order to enroll in any NMRHCA Medicare Plan.

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

D**SELECTION OF MEDICAL PLAN (check one)**

☐ BCBS Medicare Supplement Plan	Medicare Parts A and B required.
☐ BCBS Advantage PPO	Medicare Parts A and B required.
☐ BCBS Advantage HMO	IMPORTANT: If you are switching to a Presbyterian Advantage or BCBS Advantage, service area is limited to New Mexico. Medicare Parts A and B required.
☐ United Healthcare Medicare Advantage PPO + PDP	Medicare Parts A and B required. Physical address necessary.
☐ Humana Medicare Advantage PPO + PDP	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 _____