

# 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)

<input type="checkbox"/> BCBSNM Medicare Supplement PPO	<b>Medicare Parts A and B required.</b>
<input type="checkbox"/> BCBSNM Advantage PPO	<b>Medicare Parts A and B required.</b>
<input type="checkbox"/> BCBS Advantage HMO <input type="checkbox"/> Presbyterian Advantage HMO	<b>IMPORTANT:</b> If you are switching to a Presbyterian Advantage or BCBS Advantage, service area is limited to New Mexico. <b>Medicare Parts A and B required.</b>
<input type="checkbox"/> United Healthcare Advantage PPO	<b>Medicare Parts A and B required. Physical address necessary.</b>
<input type="checkbox"/> Humana Advantage Plan PPO	<b>Medicare Parts A and B required. Physical address necessary.</b>

## 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** \_\_\_\_\_