INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.
STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

Upon enrollment into Freedom Blue PPO, you agree to the following:

Freedom Blue PPO will notify you in writing of your confirmed effective date of enrollment into Freedom Blue PPO. Typically, your effective date will be the 1st day of the month that the State of Delaware enrollment lists as your effective date for the Freedom Blue PPO plan.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware is a PPO plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. or Freedom Blue PPO depends on contract renewal.

You will need to keep your Medicare Parts A and Part B. You can be in only one Medicare Advantage plan at a time, and you understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan (other than the State of Delaware Part D Prescription Drug plan).

Once you are a member of Freedom Blue PPO, you have the right to appeal Plan decisions about payment or services if you disagree. The Medical Benefits chart document along with the Freedom Blue PPO Evidence of Coverage (which is available to you) contains a full summary of the coverage rules associated with this plan. Other marketing materials present only highlights of the plan and not full coverage details.

If medically necessary, Freedom Blue PPO provides claims payment for all covered benefits, even if you get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in the Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without prior authorization (when required for select plan benefits), neither Medicare nor Freedom Blue PPO will pay for the services.

RELEASE OF INFORMATION:

Upon enrollment into this Medicare health plan, you acknowledge that Freedom Blue PPO will release your information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. You also acknowledge that Freedom Blue PPO will release your information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulation.
PERSONAL HEALTH INFORMATION

I acknowledge and agree that any “protected health information” (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Cross Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Cross Blue Shield’s Notice of Privacy Practices is available on Highmark Blue Cross Blue Shield’s Web site, or from the Highmark Blue Cross Blue Shield Privacy Department.

PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay Freedom Blue PPO the Part D-IRMAA.

Please return the top copy of both pages of the application and keep the bottom copies for your records.
TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial (if applicable)</th>
<th>Last Name</th>
<th>Suffix</th>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address (No P.O. Boxes)</th>
<th>Apt#</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (P.O. Boxes allowed)</th>
<th>Apt#</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone (with area code)</th>
<th>Email Address (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

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 the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (Part A):

You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

YOU WANT TO ENROLL IN:

☒ 295244
State of Delaware

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Cross Blue Shield health plan? ......  Yes ☐ No ☐
   If YES, name of plan:

2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? ...... Self: ......  Yes ☐ No ☐
   Your Retirement Date (Month/Day/Year): __________  Spouse’s Retirement Date (Month/Day/Year): __________
   Spouse: ......  Yes ☐ No ☐

3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ...... Yes ☐ No ☐
   If YES, please complete the enclosed “Other Insurance Addendum” and return with your completed application.

Return this copy (1 of 2 pages)
READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)  PCP/NPI # (from Provider Directory)

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM.

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)*  Yes ☐ No ☐

Are you enrolled in your State Medicaid program?  Yes ☐ No ☐

If “YES,” please provide your Medicaid Number:

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 and Phone Number of Institution (number and street):

STOP!  If you belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D), it is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) 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 Freedom Blue PPO, or by Medicare.

Signature  Today’s Date

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

Name:  Phone Number:

Address:  Relationship to Enrollee:

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

☐ I would like to receive my materials in a language other than English.

☐ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

Please contact Freedom Blue PPO at 1-888-328-2960 (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.

Return this copy (2 of 2 pages)
Other Insurance Addendum

If you answered YES to having any other Health Insurance or Prescription Drug coverage, please complete and return this form with your application. If you answered NO, you do not need to complete or return this form.

<table>
<thead>
<tr>
<th>Name</th>
<th>Medicare Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify the type of insurance:
- [ ] Active Employer Group Insurance
- [ ] Veteran’s Administration Coverage
- [ ] Federal Black Lung Coverage
- [ ] Workman’s Compensation Coverage
- [ ] Retiree Coverage
- [ ] Direct Pay Policy
- [ ] Supplemental Coverage

Please specify type of coverage:
- [ ] Medical Only
- [ ] Medical with Prescription Drugs
- [ ] Dental or Vision Only
- [ ] Prescription Drug Only

Is this insurance provided by:
- [ ] Your Employer
- [ ] Your Spouse's Employer
- [ ] Individual Plan

Does your employer have:
- [ ] 1-19 employees
- [ ] 20-99 employees
- [ ] more than 100 employees

Does your spouse’s employer have:
- [ ] 1-19 employees
- [ ] 20-99 employees
- [ ] more than 100 employees

Your employer's name: ____________________________ Your insurance name: ____________________________

Your insurance policy #: ____________________________ Your insurance group #: ____________________________

Spouse's employer's name: ____________________________ Spouse's insurance name: ____________________________

Spouse's insurance policy #: ____________________________ Spouse's insurance group #: ____________________________

Member’s Signature* ____________________________ Date ____________________________

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized to under State law to complete this form and 2) documentation of this authority is available upon request by the plan or Medicare.

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

Name: ____________________________ Phone: ____________________________

Address: ____________________________ Relationship to Enrollee: ____________________________

Highmark BCBSD Inc. is a PPO plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. depends on contract renewal.