Blue Cross Group Medicare Advantage℠

Proposed Effective Date:
__ __ / 0 1 / 2 0 __ __
(Must be after enrollee signature date)

Disabled Dependent Verification Form
TAMUS 65 Plus Medicare Advantage Plan (PPO)℠

Retiree Information	
Retiree Name:	Retiree ID/UIN:

Complete the following information for the disabled dependent:

☐ **65 Plus Medicare Advantage Plan (PPO)**	Employer: The Texas A&M University System

Dependent Legal LAST Name:	Dependent Legal FIRST Name:	Middle Initial:	Group #: PTX00024

Birth Date: __ __ / __ __ / __ __ __ __	Sex: ☐ M ☐ F

Home Phone Number: (__ __ __) __ __ __ – __ __ __ __	Alternate Phone Number: (__ __ __) __ __ __ – __ __ __ __

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code: __ __ __ __ __

Mailing Address (only if different from your Permanent Residence Street Address):

Street Address:	City:	State:	ZIP Code: __ __ __ __ __

Please provide disabled dependent Medicare insurance information:

Please take out your dependent's red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your dependent's Medicare card.

– **AND** –

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

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

Dependent Name (as it appears on your Medicare Card):

_____

Dependent Medicare Number:

__ __ __ __ __ __ __ __ __ __ __

Effective Date for:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Dependent LAST name:	Dependent FIRST name:

Please read and answer these important questions required by CMS:

1. Is the disabled dependent 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):

_____

2. Is the disabled dependent enrolled in your state Medicaid program?

☐ Yes ☐ No If **yes**, please provide your dependent's Medicaid number:

_____

Dependent LAST name: Dependent FIRST name:

Please read and sign below:

Release of Information:

By joining this Medicare health plan, I acknowledge that Blue Cross Group Medicare Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross Group Medicare Advantage will release my information, including my 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 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 from Medicare.

Signature:	**Today's Date:** ____ ____/____ ____/____ ____ ____ ____

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

Name:

Address:

Phone Number: (____ ____ ____) ____ ____ ____ – ____ ____ ____ ____

Relationship to Enrollee:

EMAIL OR MAIL VERIFICATION FORM TO:

The Texas A&M University System
Attn: Benefits Administration
301 Tarrow St., 5th Floor
College Station, TX 77840
Email: employeebenefits@tamus.edu

PPO plan provided by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC is an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment depends on contract renewal.

Dependent LAST name:	Dependent FIRST name: