

## 2014 Individual Enrollment Form

### Blue Shield Medicare Basic Plan (PDP) and Blue Shield Medicare Enhanced Plan (PDP)

Please contact Blue Shield of California if you need information in another language or format (Braille).

**Please fax or mail your completed enrollment form to:**

Fax: (877) 251-3660

Mail: Blue Shield of California

P.O. Box 948, Woodland Hills, CA 91365-9856

To enroll in a Blue Shield Medicare prescription drug plan, please provide the following information:

Please check which plan you want to enroll in:

Blue Shield Medicare Basic Plan (PDP) (\$42.80 per month)

Blue Shield Medicare Enhanced Plan (PDP) (\$74.40 per month)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	First name	Middle initial
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Birth date (MM/DD/YYYY) (___/___/____)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Home phone number (       )

Email address

**Permanent residence street address (no P.O. boxes)**

Street	City	State	ZIP code
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**Mailing address (only if different from your permanent residence address)**

Street	P.O. Box	City	State	ZIP code
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Emergency contact	Relationship to you	Phone number (       )
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- I am willing to receive required plan materials via email (i.e., enrollment notifications, the Annual Notice of Change, and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.









