SSTRIPLE-S SALUD

Triple-S Optimo PSHB Voluntary Enrollment Form

This form is for individuals who are not automatically enrolled in the Triple-S Optimo PSHB but want to enroll and meet the eligibility requirements.

Instructions

Please read these instructions carefully before you fill out the form on the next

page. To complete the form, you will need the following items:

- 1. Your Medicare member ID card
- 2. Your Triple-S Salud member ID card

Once you have the information above, fill out the form completely. Then you send it to:

Triple-S Optimo PSHB P.O. Box 3539 Scranton, PA 18505

Important: If there are multiple people in your household eligible, you will each need to send in your own form.

Questions

If you have any questions about this form, please call us toll-free at 833.201.9256 (TTY: 1.866.215.1999) Monday to Friday: 7:30am to 8:00pm (AST), Saturday: 9:00am to 6:00pm (AST), Sunday: 11:00am to 5:00pm (AST)

(Next page)

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Triple-S Salud is an independent licensee of BlueCross BlueShield Association. Medicare prescription drug benefits under the Triple-S Optimo PSHB plan are sponsored by the Blue Cross Blue Shield Association under its Medicare contract S2135

First Name: Last Name: Middle Initial: Birth Date: Sex: Male Female Prefer Not to Say Permanent U.S. Address (cannot be a PO box) Street Address: City: State: Zip Code: Phone Number: Email (Optional): Milling Address (if different than permanent address above) Street Address: City: State: Zip Code: Health Plan Information State: Zip Code: Medicare Member ID: State: Zip Code: Gat manuber for your Medicare ID card. PBP ID: 807 Acknowledgement Indecare Member ID: State: State: Set its from your member ID card. Set its from your member ID card. Set its from your member ID card. Acknowledgement I understand that by enrolling in the Triple-S Optimo PSHB I must keep my Medicare Part A and/or B coverage. I also know that this means that my information will be shared with Medicare who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Ad Statement below). Your response to this form is voluntary. However, failure to respond may atter at the plan. Lunderstand that I can be enrolled in only one Part D plan at time – and tha enrollment in this plan will automatically end my enrollment fo	Name and Cor	ntact Information								
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Name: Phone Number:										
Address: Relationship to Member:	Name:						Phone Number:			
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	Section 2 – All fields in this section are optional We will not deny your coverage if you choose not to answer these questions					
Are	Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.					
	No					
	Yes, Mexican, Mexican American, Chicano/a					
	Yes, Puerto Rican					
	Yes, Cuban					
	Yes, Other					
	Prefer Not to Answer					
Wha	What is your race? Select all that apply.					
	American Indian or Alaska Native					
	Asian					
	Black or African American					
	Native Hawaiian and Pacific Islander					
	White					
	Other					
	Prefer Not to Answer					
Req	uests for material in a different format					
	Check this box if you would like materials sent to you in Spanish Check this box if you would like materials sent to you in large print					