



MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

To enroll in Blue MedicareRx, please provide the following information:

Please select which plan you want to enroll in:

- Blue MedicareRx Standard Option**
\$30.30 a month
- Blue MedicareRx Value Option**
\$31.10 a month
- Blue MedicareRx Plus Option**
\$57.60 a month

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: _____ Sex: M F Social Security Number: _____ Home Phone Number: _____
(MM / DD / YYYY) (providing this information is optional) ()

Permanent Residence Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Street Address: _____ City: _____ State: _____ Zip Code: _____

Emergency contact: (optional field) _____

Phone Number: (optional field) _____ **Relationship to You:** (optional field) _____

E-mail Address: (optional field) _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Fill in the blanks so they match your red, white and blue Medicare card exactly.

- OR -

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

You must be entitled to Medicare Part A or enrolled in Part B (or both) to join a Medicare prescription drug plan.



Name: _____

Medicare Claim Number _____ Sex

□□□ - □□ - □□□□ □

Is Entitled To _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Your Plan Premium Payment Option

You can have the monthly premium for your Blue MedicareRx prescription drug plan automatically deducted from your monthly Social Security (SSA) check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the remainder of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want any premium you may owe deducted from your monthly SSA check.

Yes No **Would you like the premium for this plan deducted from your monthly SSA check?**

Please Answer the Following Questions to Help Medicare Coordinate Your Benefits

1. Yes No Will you have other prescription drug coverage in addition to Blue MedicareRx?

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

2. Yes No Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage (creditable coverage) since you became eligible to join a Medicare drug plan?

If no, you may have to pay a penalty. Blue MedicareRx may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have questions about the late enrollment penalty, call Blue MedicareRx at 1-888-285-2249 between 8 a.m. - 8 p.m., CST. For the hearing or speech impaired, please call 1-888-285-2252.

3. Yes No Are you a resident in a long-term care facility, such as a nursing home?

If "yes" please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

STOP

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (such as an HMO or PPO), you may already have a prescription drug benefit through your Medicare Advantage plan that will meet your needs. By joining Blue MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Blue MedicareRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue MedicareRx may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Check Each Box that Applies to You

Typically, you may only enroll in a Medicare Prescription Drug Plan during the annual enrollment period which is between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Please read the following statements and check EACH box that applies to you. Your selected plan will contact you if additional information is required. If none of the statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan. Date of Move ___ / ___ / _____
- I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- I was recently approved for extra help paying for Medicare prescription drug coverage.
- I just moved into a Long-Term Care Facility (for example, a nursing home or longer term care).
Date of Move ___ / ___ / _____
- I recently left a PACE program.
- I recently involuntarily lost my creditable drug coverage (coverage that is at least as good as Medicare's).
- I am either losing coverage I had from an employer or leaving employer coverage.

Please Read and Sign Below

By completing this enrollment form, I agree to the following:

Blue MedicareRx is a Medicare-approved drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Blue MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue MedicareRx or by calling 1-800-MEDICARE (1-800-633-4227). For the hearing or speech impaired, please call 1-877-486-2048 (24 hours a day, 7 days a week).

Blue MedicareRx serves a specific service area. If I move out of the area that Blue MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Blue MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) on this form means that I have read and understand the contents of this enrollment form. 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 form and 2) documentation of this authority is available upon request by Blue MedicareRx or by Medicare.

Your Signature: **X** _____ Today's Date: _____

Requested Effective Date: _____ (Please note that CMS enrollment guidelines may not allow for us to accommodate your requested effective date. Your enrollment confirmation letter will include your actual effective date.)

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

Name: _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative Signature: **X** _____

SM Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

® Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Blue Cross and Blue Shield of Illinois refers to HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Part D products under HCSC Insurance Services Company's contract S5715 with the Centers for Medicare and Medicaid Services.