



## MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

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

### Please check which plan you want to enroll in:

- Blue MedicareRx Standard Option**  
\$31.60 a month
- Blue MedicareRx Value Option**  
\$27.80 a month
- Blue MedicareRx Plus Option**  
\$70.10 a month

LAST Name:                      FIRST Name:                      Middle Initial:                       Mr.     Mrs.     Ms.

Birth Date:                      Sex:                      Social Security Number:                      Home Phone Number:  
 (   /   /     )     M     F    (providing this information is optional)    (       )  
( M M / D D / Y Y Y Y )

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.

- 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 the Social Security Administration or Railroad Retirement Board.

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



SAMPLE ONLY

Name: \_\_\_\_\_

Medicare Claim Number                      Sex

-   -

Is Entitled To                      Effective Date

**HOSPITAL (Part A)** \_\_\_\_\_

**MEDICAL (Part B)** \_\_\_\_\_

## Information to Determine Enrollment Periods

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

Please review the following statements, then check the box that applies to you. If additional information is necessary, Blue Cross and Blue Shield of Illinois will contact you.

- I am new to Medicare.
- I recently moved outside of my current Medicare health plan's or Medicare prescription drug plan's service area.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help or I am no longer eligible for extra help paying for Medicare prescription drug coverage.
- I live in a Long Term Care Facility (for example, a nursing home or long term care facility).
- I just moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my coverage that is creditable prescription drug coverage (as good as Medicare's).
- I am either losing coverage I had from an employer or leaving employer coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.

If none of these statements applies to you, or if you are not sure, please contact us at 1-888-285-2249 8 a.m. – 8 p.m., CST, 7 days a week, to see if you are eligible to enroll. For the hearing or speech impaired, please call 1-888-285-2252.

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

To ensure timely processing of your enrollment and determine if your requested effective date can be accommodated, it is imperative we understand the date associated with the reason (e.g. date of move; date creditable coverage ends) checked above. Please insert that date here:   /   /



## 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 through an employer or union, joining Blue MedicareRx may change how your current coverage works. Carefully read the correspondence your employer or union sends you. If you have questions, visit their website, or contact the office listed in their correspondence. If there is no information on whom to contact, your Benefits Administrator or the office that answers questions about your coverage can help.

## Paying Your Plan Premium:

You can pay your monthly plan premium by mail, by “Electronic Funds Transfer (EFT)”, or by automatic deduction from your Social Security Check. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don’t select a payment option, you will receive a bill each month. Generally you must stay with the option you choose for the rest of the year.

### Please select a premium payment option:

- Receive a bill**
- Electronic funds transfer (EFT) from your bank account each month**

Account holder name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

Account type:  Checking  Savings

- Automatic deduction from your monthly SSA benefit check.** (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

### Please Answer the Following Questions:

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

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

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. 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 (number and street) & Phone Number of Institution: \_\_\_\_\_

### Please Read and Sign Below

#### **By completing this enrollment application, I agree to the following:**

Blue MedicareRx is a Medicare 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 — if I am currently in a Medicare prescription drug plan, my enrollment in Blue MedicareRx will end that enrollment. 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, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

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.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare’s), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

(over, please)

## Please Read and Sign Below (cont'd)

### 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. I also acknowledge that Blue MedicareRx will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

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 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 Blue MedicareRx or by Medicare.

Your Signature: **X** \_\_\_\_\_ Today's 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): \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Plan Representative Signature: **X** \_\_\_\_\_

### Agent Information If Applicable: (Please Print)

**Note:** This section should identify the agent OR agency to be compensated for this applicant.

Agent or Agency Name: \_\_\_\_\_

Agent Code: (i.e., Tax ID#/SS#) \_\_\_\_\_

Signature of Agent: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Agency Name: (if applicable) \_\_\_\_\_

The person that is discussing plan options with you is either employed by or contracted with Blue MedicareRx. This person may be compensated based on your enrollment in Blue MedicareRx.

<sup>SM</sup> Service Mark 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.