BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.℠

Blue MedicareRx (PDP)℠

MEDICARE PRESCRIPTION DRUG PLAN

2010 Individual Enrollment Form

Follow these easy steps:

1. Review the Summary of Benefits included in your 2010 Blue MedicareRx (PDP) Decision Guide.

2. Enroll:

- Complete and return this form in the enclosed postage-paid envelope. Keep the blue copy for your files. If you don't have a postage-paid envelope (see last page), please mail your completed enrollment form to:
  Blue MedicareRx (PDP), P.O. Box 3897, Scranton, PA 18505-0897, or
- Complete the online form at www.bcbstx.com/pdpenrollnow, or
- Call a Product Specialist to enroll over the phone at the number below, or
- Contact your authorized independent agent

For assistance with eligibility, enrollment, or for information in another format, call:

1-877-296-8195

TTY/TDD 1-888-285-2252

Hours of Operation: 8 a.m. – 8 p.m. Central time, 7 days a week.

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:	
☐ Spanish ☐ Braille	Please contact Blue MedicareRx (PDP) at 1-877-296-8195 if you need information in another format or language than what is listed to the left. TTY users should call 1-888-285-2252. Our office hours are 8 a.m. - 8 p.m., Central time, 7 days a week.

STOP **Please Read This Important Information:**

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Blue MedicareRx (PDP), your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. 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 (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue MedicareRx (PDP). 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 isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

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

Please check which plan you want to enroll in:

☐ **Value Plan** $33.30	☐ **Standard Plan** $39.00	☐ **Plus Plan** $67.50

Last Name:		LC:
First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ☐☐ ☐☐ ☐☐☐☐ (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )

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

Street Address:		
City:	State:	ZIP Code:

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

Street Address:		
City:	State:	ZIP Code:

Optional Information:

E-mail Address:	
Emergency contact:	
Phone Number:	Relationship to You:

Please Provide Your Medicare Insurance Information.

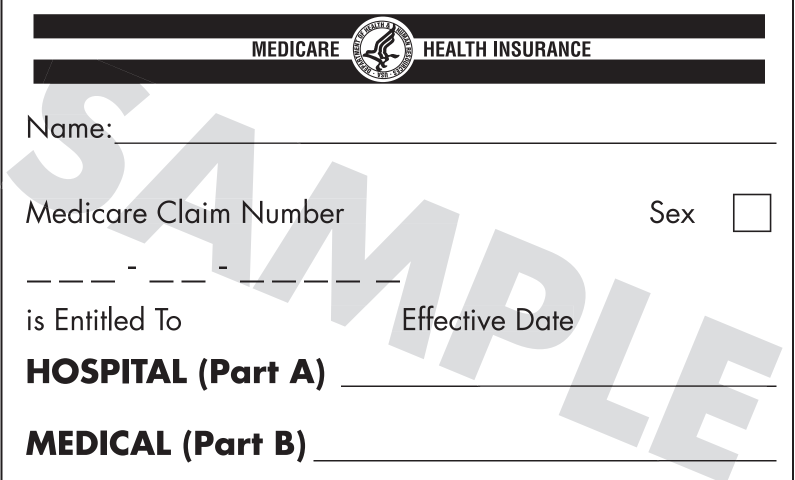
Please take out your Medicare card to complete this section.

- 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 Social Security or the Railroad Retirement Board.

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



Subscriber acknowledges this agreement is a contract solely with Blue Cross and Blue Shield of Texas (BCBSTX), an independent licensee of the Blue Cross Blue Shield Association, and that BCBSTX is not contracting as the agent of the Association. Subscriber acknowledges that it has not entered into this agreement based on representations by any other party than BCBSTX and that no person or entity, other than BCBSTX shall be held accountable or liable to Subscriber for any of BCBSTX's obligations under this agreement.

Please read carefully before signing below

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

Blue MedicareRx (PDP) is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue MedicareRx (PDP) 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 (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for certain special circumstances. Blue MedicareRx (PDP) serves a specific service area. If I move out of the area that Blue MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue MedicareRx (PDP) network pharmacies. Once I am a member of Blue MedicareRx (PDP), 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 (PDP) when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue MedicareRx (PDP) he/she may be paid based on my enrollment in Blue MedicareRx (PDP).

Counseling services may be available in my state to provide advice concerning Medicare Supplement Insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Blue MedicareRx (PDP) 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 (PDP) 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 State law 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 by Blue MedicareRx (PDP) or by Medicare.

Enrollee Signature:	**Today's Date:**
X ____________________	☐☐/☐☐/☐☐☐☐

If you are the authorized representative (i.e. power of attorney), you must sign below and provide the following information:

Name:		Phone #: ( )
Address:		
City:	State:	ZIP:
Relationship to Enrollee:		

Authorized Representative Signature:

X ____________________

Please indicate who should receive all required notifications and plan materials:

☐ Enrollee ☐ Authorized Representative listed above ☐ Both

Please Provide Information to Determine Enrollment Periods.

Review the following statements carefully and check the box of the statement that, to the best of your knowledge, applies to you. If additional information is necessary, we will contact you.

To ensure timely processing of your enrollment and determine if your requested effective date can be met, we may need to know the date associated with the reason checked below (e.g. date of move).

- ☐ I am enrolling during the Annual Enrollment Period (November 15 - December 31).
- ☐ I am new to Medicare. ☐☐/☐☐/☐☐
- ☐ I have moved and this plan is a new option for me. ☐☐/☐☐/☐☐
- ☐ I have Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I live in a long-term care facility.
- ☐ I have moved out of a long-term care facility. ☐☐/☐☐/☐☐
- ☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. ☐☐/☐☐/☐☐
- ☐ I involuntarily lost my creditable prescription drug coverage (as good as Medicare's). ☐☐/☐☐/☐☐
- ☐ I am either losing or leaving coverage from an employer/union. ☐☐/☐☐/☐☐
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I am leaving a Medicare Advantage Part D (MAPD) plan during the Medicare Advantage Open Enrollment Period to enroll in Original Medicare and this Part D plan. (January 1 - March 31 only)
- ☐ None of these statements applies to me or I am unsure.

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

Please Answer the Following Questions:

1. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Blue MedicareRx (PDP)? ☐ Yes ☐ No
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

Name of Institution:

Street Address:	City:	State:	ZIP Code:

Paying Your Premium

If you don't select a payment option, you will receive a monthly bill.

Premiums may be paid by mail, monthly Electronic Funds Transfer from your bank account or deduction from your Social Security benefit 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 doesn't cover.

Select a payment option: ☐ Receive a bill ☐ Monthly Electronic Funds Transfer (EFT) ☐ Deduct from SSA check

Account holder name:

Bank routing number: | Bank account number:

Account type: ☐ Checking (Enclose a voided check.) ☐ Saving

Medicare Prescription Drug Plan Use Only:

☐ Check here if this applicant was referred by a producer.

Effective Date of Coverage:	Date: ☐☐/☐☐/☐☐	☐ IEP	☐ AEP	☐ SEP (type):

Plan Representative Signature: X ______________________	Assigned #:	Date: ☐☐/☐☐/☐☐

Certified Agent/Producer Information (If Applicable):

As the producer signing this application, I attest that I have completed the CMS required 2010 **annual** Medicare prescription drug plan training and certification provided by Blue Cross and Blue Shield of Texas. I further attest that all information provided in this section is true. I understand that providing false information can lead to disciplinary action up to and including loss of commission payments and termination of the Blue MedicareRx (PDP) amendment.

This section MUST be completed by the certified PRODUCER who assisted in this enrollment. The Certified Producer/Agency "Assigned Number" indicated below will be used to validate certification and provide compensation to the Certified Producer OR Agency (if applicable).

Please print:

Name:	BCBSTX Assigned Number:
Agency Name (if applicable):	Agency ID:
Producer Signature: X ______________________	Date: ☐☐/☐☐/☐☐
Producer Phone Number: ( )	

Scope of Appointment:	Yes	No
Did you meet with the enrollee in person?	☐	☐
If yes:		
Did you retain a copy of the signed Scope of Appointment Form?	☐	☐
If no:		
Did you use the Audio Audit recording service to set up the appointment?	☐	☐

List the date and time of the appointment.	Date: ☐☐/☐☐/☐☐	Time:

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Blue Cross and Blue Shield of Texas 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 contract number S5715 with the Centers for Medicare and Medicaid Services.

White copy - Blue Medicare Rx (PDP) Blue Copy - Enrollee