

# 2009 BlueRx® Medicare Prescription Drug Plan Enrollment Form

Personal Information			FOR OFFICE USE ONLY					
Applicant's Name (Last/First/Middle Initial)								
Address (Number & Street)	County	City	State	Zip				
Mailing Address (If different from permanent address)	County	City	State	Zip				
Social Security No. (Providing this information is optional)	Date of Birth (Month/Day/Year)		Telephone (Area Code)					
			( )	-				

**Medicare Information - Please take out out your Medicare card to complete this section.**

- 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 B (or both) to join a Medicare Prescription Drug Plan.)

*We cannot consider this enrollment form completed until you have given us this information.*

MEDICARE		HEALTH INSURANCE
SAMPLE ONLY		
Name: _____		
Medicare Claim Number _____		Sex _____
_____ - _____ - _____		
Is Entitled To	Effective Date	
HOSPITAL (Part A)	_____	
MEDICAL (Part B)	_____	

**Premium Information - Please choose which plan to want to enroll in:**

**If you did not enroll in a Medicare Part D plan when you initially became eligible, you may pay a penalty in addition to the premiums listed below.**

- Option I \$31.20 per month       Option II \$53.70 per month

**Please Read and Answer the Following Questions:**

1. Some individuals 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 BlueRx?  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: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Address of Institution: \_\_\_\_\_

**Paying Your Plan Premium - Please select one payment method:**

- You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT) or credit card each month.
- You can also choose to pay your premium by automatic deduction from your Social Security Check each month.
- 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.*

- Electronic Funds Transfer (EFT) - Please complete and attach the enclosed Authorization Agreement with a blank voided check.**
- Monthly Billing Statement – You will receive a bill each month for your plan premium.**
- Credit Card or Debit Card – Please complete and attach the enclosed Authorization Agreement for Credit Card Payments.**
- Automatic Deduction from Your Monthly Social Security Benefit Check - The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.**

**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 a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining **BlueRx**, 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 **BlueRx** could affect your employer or union health benefits. If you have health coverage from an employer or union, joining **BlueRx** 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.*

**Application Agreement:**

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

**BlueRx** 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 coverage. It is my responsibility to inform **BlueRx** 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 **BlueRx** 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.

**BlueRx** serves a specific service area. If I move out of the area that **BlueRx** 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 to access **BlueRx** benefits, except under limited, non-routine circumstances when I cannot reasonably use **BlueRx** network pharmacies. Once I am a member of **BlueRx**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **BlueRx** 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. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with **BlueRx**, he/she may be compensated based on my enrollment in **BlueRx**.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning 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 **BlueRx** will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that **BlueRx** 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 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 **BlueRx** or by Medicare.

**Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

*If you are the authorized representative, you must sign above and provide the following information:*

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

**Address:** \_\_\_\_\_

**Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Relationship to Enrollee** \_\_\_\_\_

**Licensed Agent Use Only**

*I certify that I have truly and accurately recorded on this application the information supplied by the applicant.*

**Licensed Agent:** \_\_\_\_\_ **Agent ID #** \_\_\_\_\_ **Date Received:** \_\_\_\_\_

**Agent Signature:** \_\_\_\_\_ **Document ID Number:** \_\_\_\_\_