



## 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 **BlueRx (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 **BlueRx (PDP)** could affect your employer or union health benefits. You could lose your employer or union health coverage if you join **BlueRx (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 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 (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 and Part B coverage. It is my responsibility to inform **BlueRx (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 **BlueRx (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.

**BlueRx (PDP)** serves a specific service area. If I move out of the area that **BlueRx (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 **BlueRx (PDP)** network pharmacies. Once I am a member of **BlueRx (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 **BlueRx (PDP)** when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and do not 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 **BlueRx (PDP)**, he/she may be paid based on my enrollment in **BlueRx (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 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 (PDP)** will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that **BlueRx (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 **BlueRx (PDP)** or by Medicare.

# BlueRx® (PDP) ENROLLMENT REQUEST FORM

**Open the enrollment request form and print clearly with a black ball point pen.**

- **Press hard enough so that your writing appears on the yellow copy.**
- **Be sure to complete all required fields and answer all questions.**
- **Be sure to read the important disclosures listed on the back before completing this application.**
- **Sign and date the second page of the enrollment form.**
- **Remove the yellow copy and keep it for your records.**
- **Mail the enrollment request form in the envelope provided.  
Or to the address below:**

**BlueCross BlueShield of Tennessee  
BlueRx (PDP)  
Attn: Payment Processing  
P.O. Box 2768  
Birmingham, AL 35202-2768  
Fax Number: 1-888-246-0230**



BlueRx (PDP) is a Medicare approved Part D sponsor.

BlueRx is a Regional Medicare prescription drug plan provided by Blue Cross and Blue Shield of Alabama and BlueCross BlueShield of Tennessee, Independent Licensees of the BlueCross and BlueShield Association. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association © Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

**To Enroll in BlueRx (PDP), Please Provide the Following Information:**

PERSONAL INFORMATION				FOR OFFICE USE ONLY						
Applicant's Name (Last/First/Middle Initial)										
Permanent Residence Street Address		County	City		State	Zip				
MAILING ADDRESS (If different from permanent address)		County	City		State	Zip				
Sex <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (Month/Day/Year):							Telephone (Area Code) ( ) _____ - _____		

**MEDICARE INFORMATION**

**Please take 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 Social Security or the Railroad Board. (You must have Medicare Parts A and B 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: _____	Sex _____
Medicare Claim Number _____	_____
Is Entitled To	Effective Date
HOSPITAL (Part A) _____	_____
MEDICAL (Part B) _____	_____

**PREMIUM INFORMATION Please choose which plan you want to enroll in:**

Option I \$28.50 per month  Option II \$61.10 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 (PDP)?  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 (number and street): \_\_\_\_\_

**Please check one of the boxes below if you would prefer that we send you information in another format:**  
 Audio Tape  CD

*Please contact BlueRx (PDP) at 1-800-841-7434 (TTY users should call 1-888-423-9490) if you need information in another format than what is listed above. Our office hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 1 to September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.*

**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 benefit check each month.
- 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](http://www.socialsecurity.gov/prescriptionhelp).
- 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.**
- Get a Bill Monthly – 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.**

**IMPORTANT: Read the back of the Enrollment Form and sign below.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State 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 **BlueRx (PDP)** 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 No.: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ 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 Rec'd: \_\_\_\_\_

Agent Signature: \_\_\_\_\_