

Instructions on How to Fill Out the Blue MedicareRxSM (PDP) Enrollment Form

Please review all plan information carefully before making your selection. Once you have selected a plan, make sure you:

- Check which plan you want to enroll in.
- Fill out the form completely, including your personal information and permanent residence street address (and mailing address only if different from your permanent residence street address).
- Write in your Medicare information or enclose a copy of your Medicare card or a copy of the verification letter of your Medicare entitlement from Social Security or the Railroad Retirement Board.
- You can find out if you are eligible for extra help to pay for your prescription drug costs by contacting your local Social Security office, or by calling Social Security at the number provided on the form, or by applying online at www.socialsecurity.gov/prescriptionhelp.
- Fill out the section on other drug coverage, as enrollment in a Blue MedicareRx (PDP) plan may affect the drug coverage you currently have.
- Fill out the section on being a resident of a long-term care facility such as a nursing home, and include the institution's name, address and phone number.
- Read the Important Information and Agreement sections. If you have any questions, call Blue MedicareRx (PDP) at 1-866-832-9702 (TTY: 1-866-552-6288), from 8 a.m. to 8 p.m. EST, 7 days a week.
- Sign and date the enrollment form before returning it to us. Any enrollment forms received unsigned cannot be processed and may result in delayed enrollment.
- Once you have completed filling out the Enrollment Form, please return it to us in the business reply envelope provided.

If you are filling out the enrollment form for someone else:

- Please be sure to sign the enrollment form and note your contact information and relationship to the enrollee. If you are authorized to act on behalf of the enrollee under the laws of the state that the enrollee resides, your signature certifies that:
 - You are authorized under State law to complete this enrollment, and
 - Documentation of this authority is available upon request.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx plans. The joint enterprise is a Medicare approved Part D Sponsor.

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Blue MedicareRxSM (PDP) Medicare Prescription Drug Plan Individual Enrollment Form

Please contact Blue MedicareRx Value (PDP), Blue MedicareRx Value Plus (PDP), or Blue MedicareRx Premier (PDP) if you need information in another format (Large Print).

To Enroll in Blue MedicareRx (PDP), Please Provide the Following Information:

Please check which plan you want to enroll in:

- Blue MedicareRx Value (PDP)** \$47.70 per month
- Blue MedicareRx Value Plus (PDP)** \$53.10 per month
- Blue MedicareRx Premier (PDP)** \$92.70 per month

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

Birth Date: _____ Sex: M F Home Phone Number: _____
(MM/DD/YYYY)

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

City: _____ State: _____ ZIP Code: _____

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

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____

Phone Number: _____ **Relationship to You:** _____

Email Address: _____

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.



Name: _____

Medicare Claim Number _____ Sex _____

_____ - _____ - _____

Is Entitled To _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium

You can pay your monthly plan premium by mail 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.

If you qualify for extra help with your Medicare prescription drug 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.

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

Please select a premium payment option:

- Receive a bill
- 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.)

Please 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 Blue MedicareRx (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: _____

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

Please check the box below if you would prefer that we send you information in another format:

Large Print

Please contact Blue MedicareRx (PDP) at 1-866-832-9702 if you need information in a format other than what is listed above. TTY users should call 1-866-552-6288. Our office hours are 8 a.m. to 8 p.m. EST, 7 days a week.



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.

Please Read and Sign 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.

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage Plan or Medicare Prescription Drug Plan.

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.

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 _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

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

Plan Representative/Agent/Broker Signature: _____

CT Agents/Brokers: Please check which code to use for commission payment:

Agent/Broker Code Number: _____

Agent/Broker Name: _____

Agency Code Number: _____

Agency Name: _____

CT Field Rep Name: _____ Code Number: _____ Signature: _____

CT Inside Rep Name: _____ Code Number: _____ Signature: _____

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