Blue Cross Blue Shield of Rhode Island

Blue MedicareRx℠ (PDP)

Instructions on How to Fill Out the Blue MedicareRx℠ (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.
- Review the section on the Enrollment Eligibility and choose the scenario that best describes your eligibility status.
- 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 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 at 1-888-496-4174 (TTY: 1-866-552-6288), 24 hours a day, 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; or mail it directly to Blue MedicareRx P.O. BOX 52067, Phoenix, AZ 85072-9854.

Note: If you would like to save time and enroll online in one of our Blue MedicareRx plans, please go to www.RxMedicarePlans.com, select your state and then click on the "Enroll" tab to complete our secure online enrollment form.

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.

Blue Cross Blue Shield of Rhode Island

Blue MedicareRx℠ (PDP)

Blue MedicareRx[SM] (PDP) Medicare Prescription Drug Plan Individual Enrollment Form

Please contact 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 Plus** $33.30 per month ___ **Blue MedicareRx Premier** $99.70 per month

LAST Name:	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)*:

City:	**State:**	**ZIP Code:**

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

Street Address: City: State: ZIP Code:

Emergency contact*: [Optional]* _____

Phone Number: *[Optional]* _____ **Relationship to You** *[Optional]*_____

E-mail Address: *[Optional]*

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

__ __ __ –__ __–__ __ __ __ ___ ☐ M ☐ F

Is Entitled To Effective Date

HOSPITAL (Part A) __ __ –__ __–__ __

MEDICAL (Part B) __ __ –__ __–__ __

Enrollment Eligibility

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between October 15 and December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period. Please read the below statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

□ I am applying during Annual Enrollment period (October 15 through December 7) for an effective date of January 1.

□ I am new to Medicare.

□ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) __ __ /__ __ /__ __ __ __.

□ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) __ __ /__ __ /__ __ __ __.

□ I have both Medicare and Medicaid or my state helps pay for Medicare premiums.

□ I get extra help paying for Medicare prescription drug coverage.

□ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) __ __ /__ __ /__ __ __ __.

□ I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or a long term care facility. I moved/will move into/out of the facility on (insert date) __ __ /__ __ /__ __ __ __.

□ I recently left a PACE program on (insert date) __ __ /__ __ /__ __ __ __.

□ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) __ __ /__ __ /__ __ __ __.

□ I am leaving employer or union coverage on (insert date) __ __ /__ __ /__ __ __ __.

□ I belong to a pharmacy assistance program provided by my state.

□ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

□ I am making this enrollment request between January 1 and February 14, and I recently ended or plan on ending my enrollment in a Medicare Advantage plan. The date that my Medicare Advantage Plan ends/ended on is (insert date) __ __ /__ __ /__ __ __ __.

If none of these statements applies to you or you're not sure, please contact us at 1-888-496-4174 to see if you are eligible to enroll. We are open 24 hours a day, 7 days a week. TTY users call 1-866-552-6288.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Blue MedicareRx.

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 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.

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 *OR* ☐Railroad Retirement Board benefit check.** (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deductions, we will send you a paper bill for your monthly premiums.)

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? ☐ 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 at 1-888-496-4174 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 24 hours a day, 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, 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 could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue MedicareRx. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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 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 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. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

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. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue MedicareRx network pharmacies. 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 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, he/she may be paid based on my enrollment in Blue MedicareRx.

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 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 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 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 Office & Producer 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: _____

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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 (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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