Connecticut | Massachusetts
Rhode Island | Vermont

Blue MedicareRx℠ (PDP)

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

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

Please review all plan information carefully before making your selection. Once you have selected a plan, make sure you use this checklist to ensure you have filled out the application completely:

- ☐ **IMPORTANT**: 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.
- ☐ **IMPORTANT**: Review the section on the Enrollment Eligibility carefully and choose the scenario that best describes your eligibility status
- ☐ 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.
- ☐ 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 **1-800-772-1213** (TTY users should call **1-800-325-0778**), or by applying online at **www.socialsecurity.gov/prescriptionhelp**.
- ☐ Read the Important Information and Agreement sections. If you have any questions, call Blue MedicareRx:

Connecticut Residents: **1-866-832-9702 (TTY: 711)** 24 hours a day, 7 days a week	**Massachusetts Residents:** **1-800-678-2265 (TTY: 711)** 10/1–3/31, 7 days a week, 8:00 a.m. to 8:00 p.m., 4/1–9/30, Monday through Friday 8:00 a.m. to 8:00 p.m.	**Rhode Island Residents:** **1-800-505-2583 (TTY: 711)** Monday through Friday 8:00 a.m. to 8:00 p.m.	**Vermont Residents:** **1-888-496-4178 (TTY: 711)** 24 hours a day, 7 days a week
Online: rxmedicareplans.com			

- ☐ 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 30001, Pittsburg, PA 15222-0330.

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 where 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.

If you need an appointment of representative (AOR) form, please note that it will be included in your new enrollment kit.

Connecticut | Massachusetts
Rhode Island | Vermont

Blue MedicareRx[SM] (PDP) 2019

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** $37.80 per month ☐ **Blue MedicareRx Premier** $127.90 per month

LAST Name:	FIRST Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __ /__ __ /__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Primary Phone Number: ( )	Alternate Phone Number: ( )

E-mail Address: *[Optional]* _____

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 Field]* _____

Phone Number: *[Optional]* _____

Relationship to You *[Optional]*_____

Please Provide Your Medicare Insurance Information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Is Entitled to: Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

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 the Annual Enrollment period **(October 15 through December 7)** for an effective date of **January 1**.

I am new to Medicare.

□ 65th Birthday
□ Disability Determination
□ Existing Medicare (via disability)–Now turning 65

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

Medicare Assistance Programs.

□ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

□ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

□ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. I am making this enrollment request between January 1 and September 30 and I understand I can only make this request once per quarter.

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

□ I recently left a PACE program.

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

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

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

□ I am leaving employer or union group coverage on

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

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

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

Change in Residence

□ 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 recently returned to the United States after living permanently outside of the U.S.

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

□ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) between January 1 and March 31.

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

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

(insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

□ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) (__ __/__ __/__ __ __ __)
(M M/D D/ Y Y Y Y)

□ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

□ Other Explain:_____

If none of these statements applies to you or you're not sure, please contact us to see if you are eligible to enroll.

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Online: rxmedicareplans.com			

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 of Institution (number and street): _____

Phone Number of Institution: _____

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

☐ Large Print

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Online: rxmedicareplans.com			

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.

Please select a premium payment option. (If you don't select an option, you will receive a monthly bill.) Reminder, if you have secondary coverage that pays for part of your premiums (for example: from your employer or an SPAP) then you must choose monthly bills that you can pay by mail in order for the secondary coverage to be applied correctly.

☐ **Receive a bill**

☐ **Automatic Bank Draft Withdrawal from Checking or Savings Account**

Please send us a VOIDED check and fill in the requested information, which allows us to deduct your monthly premium payment from your bank account. ☐ **Checking** ☐ **Savings (check one)**

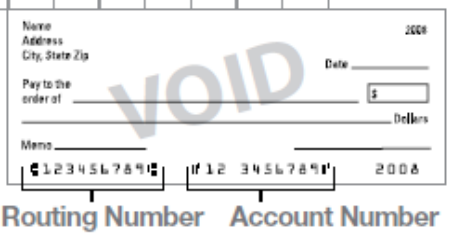
Name on Account

Financial Institution

Routing Number

Account Number

Account Holder Signature _____



By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization named above to pay my premium through electronic bank withdrawal payable to Blue MedicareRx. I authorize the deduction of up to $300 at a time (only if the balance is such). The bank or other financial organization will be fully protected in honoring these payments until notice from me canceling this request is received.

☐ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.**

I get monthly beneifts from: ☐ Social Security ☐ RRB

(Your monthly plan premium deduction **may take up to 90 days to begin** and will not cover any premiums for which we have already sent you an invoice. Therefore, until your automatic deduction is approved, we will continue to send you a paper bill each month. **Please continue to pay your premium invoice for as long as you receive it.** In most cases, if Social Security/ Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit might not include all premiums owed from your enrollment effective date up to the point withholding begins. If you owe any premiums retroactive to the date of the Social Security/Railroad Retirement Board deductions, we will send you a paper bill for those premiums. If Social Security/ Railroad Retirement Board does not approve your request for automatic deductions, we will send you a paper bill for your monthly premiums.) **Note**: the option to pay using a **Credit Card** will be included on your monthly invoice. You can also call us toll free once your enrollment in the plan is active.

Paying Your Plan Premium

Connecticut Residents:	Massachusetts Residents:	Rhode Island Residents:	Vermont Residents:
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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 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 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 understand that I may only leave this plan or make changes during the Annual Enrollment Period (October 15 – December 7 each year), unless I qualify for a special enrollment period sooner under certain special circumstances allowed by CMS.

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 _____

Note : If you need an appointment of representative (AOR) form, please note that it will be included in your new enrollment kit.

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24 hours a day, 7 days a week	10/1–3/31, 7 days a week, 8:00 a.m. to 8:00 p.m., 4/1–9/30, Monday through Friday 8:00 a.m. to 8:00 p.m.	Monday through Friday 8:00 a.m. to 8:00 p.m.	24 hours a day, 7 days a week

Online: rxmedicareplans.com

Broker Box for Connecticut and Rhode Island Only:

Medicare Prescription Drug Plan Office & Producer Use Only:

Date Application Received by Agent/Broker/Rep:_____

Effective Date of Coverage: _____

Enrollment Period Type: IEP:☐ AEP:☐ SEP:☐

Agent Individual Writing Code: _____

Agent/Broker/Rep Name:_____

Agent/Broker/Rep Signature:_____

Agent/Broker/Reps Only – please fax the completed application to the following number within 24 hours of receipt:

Connecticut: **1-866-342-7048**

Rhode Island: **1-401-459-5025**