2021 MedicareBlue^{SM} Rx (PDP) Individual Change Form

Complete this form only if you wish to change your MedicareBlue Rx plan option.

Easy options to change plans

Online at **YourMedicareSolutions.com**

Call **1-866-434-2037**, 8 a.m. to 8 p.m., daily, Central and Mountain times
(TTY: **711**)

Fill out the change form and mail to:

MedicareBlue Rx (PDP)
P.O. Box 3178
Scranton, PA 18505

Contact your independent certified agent

OMB No. 0938-1378
Expires: 7/31/2023

Who can use this form?

People with Medicare who want to change their Medicare Prescription Drug Plan

To change plans, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To change your Prescription Drug Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can change plans:

- Between October 15–December 7 each year (for coverage starting January 1)
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can change plans.

What do I need to complete this form?

- Your permanent address and phone number

Note: You must complete all items on page 1. The item on page 5 is optional — you can't be denied coverage because you don't fill it out.

Reminders:

- If you want to change plans during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
MedicareBlue Rx
P.O. Box 3178
Scranton, PA 18505

Once they process your request to change plans, they'll contact you.

How do I get help with this form?

Call MedicareBlue Rx Solutions specialists at **1-866-434-2037**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users can call **1-877-486-2048**.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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2021 MedicareBlue Rx individual change form

A. Member information (please print clearly)

Last name:	First name:	Middle initial:
Member number (Printed on your MedicareBlue Rx ID card):	Medicare number (Printed on your red, white and blue Medicare ID card):	
Home phone number: ( ) –	Alternate phone number (optional): ( ) –	Email address:
Permanent residence street address **(Don't enter P.O. Box)**:		
City:	State:	ZIP code:

B. Plan options (for premium information, see your Summary of Benefits)

Please check the box below for the plan option you wish to change to:
MedicareBlue Rx: ❑ Standard ❑ Premier

C. Enrollment period determination

Typically, you may enroll or change plan options in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to change your plan option in a Medicare Prescription Drug Plan outside of the annual enrollment period. Please read the following 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. **Note: A choice of effective date is only allowed in certain enrollment situations identified below.** In all other cases, or if you do not specify an effective date, your effective date will generally be the first of the month after your form is received by the plan.

IF THE STATEMENT YOU SELECT REQUIRES A DATE, PLEASE USE THE FOLLOWING FORMAT:

M	M	D	D	Y	Y	Y	Y

ANNUAL ENROLLMENT PERIOD

❑ I am enrolling during the annual enrollment period, October 15 to December 7, for **a January 1, 2021 effective date.** (Note: The change form must be received by December 7 for the enrollment to be effective on January 1.)

I AM MOVING OR HAVE MOVED

❑ I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on the following date:

								.

Enrollee name: _____

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I LOST OR AM LOSING MY COVERAGE OR EXTRA HELP

❑ 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 the following date: ☐☐☐☐☐☐☐☐.

❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on the following date: ☐☐☐☐☐☐☐☐.

❑ 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 HAVE OTHER COVERAGE (ANO OTHER REASONS)

❑ 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.

❑ I belong to Big Sky Rx (a state pharmaceutical assistance program) provided by the state of Montana.

❑ Other special enrollment period not identified above _____

If none of the statements apply to you or if you are not sure, please contact MedicareBlue Rx (the phone numbers are on the front of this form) to see if you are eligible to enroll.

D. Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. This amount is usually taken out of your Social Security benefit or you may get a bill from Medicare (or the RRB). Do NOT pay MedicareBlue Rx the Part-D IRMAA.

Enrollee name: _____

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Select a premium payment option:

❑ Keep my current premium payment option.

❑ Receive a paper bill. **Do not send a premium payment with this application.**

❑ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:

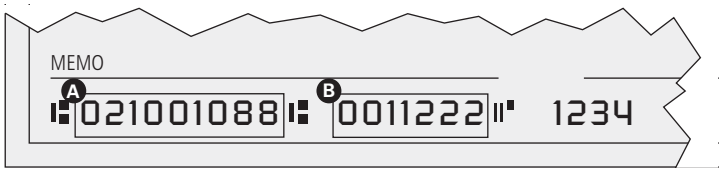
Account holder name: _____

Financial institution: _____

Bank routing number: | | | | | | | | | |

Bank account number: | | | | | | | | | | | | | | | | |

Account type: ❑ Checking ❑ Saving



Ⓐ The bank routing number is nine characters long and appears between the ⑆ symbols, usually at the bottom left corner of your check.

Ⓑ Your account number is 5 to 17 characters long and appears next to the ⑈ symbol at the bottom of your check, usually to the right of your bank routing number.

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ❑ Social Security ❑ RRB

E. Please read section F of change form and sign below

I want to transfer from my current plan option to the plan option I have selected here. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this change form, including the information in Section F. If signed by an authorized representative (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.

Your signature: _____ **Today's date:** _____

❑ I give permission to the licensed agent identified below to enter my change form online through **YourMedicareSolutions.com**.

Enrollee name: _____

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For authorized representative use only

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

Name (Print): _____ Phone number: (____) _____

Address: _____

City: _____ State: _____ ZIP code: _____

Relationship to enrollee: _____

❑ I want all mail for this member sent to me.

For agent use only

Agent name (print): _____

Agent #: _____ Agency #: _____

❑ Check if you have received this **completed** enrollment form with the enrollee's signature from the enrollee. This paper form must be submitted using one of the methods below within **two (2) calendar days** of the date you receive it. Sign and date below when you receive the form from the beneficiary.

Agent signature: _____

Date form received: _____ Phone number: (____) _____

Check selected submission method and enter information as appropriate:

❑ Paper to online application. Enter online confirmation number:

_____

❑ Application faxed. Enter date faxed (keep fax confirmation sheet):

_____

❑ Application sent overnight. Be sure to keep the overnight receipt.

F. Enrollment authorization: By completing this enrollment application, I agree to the following

After carefully reading the statements in this section, please sign Section E of this form.

1. I must keep Part A or Part B to stay in MedicareBlue Rx.
2. By joining this Medicare prescription drug plan, I acknowledge that MedicareBlue Rx will share my information with Medicare, who may use it to track my enrollment, to make payments,and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on page 5).
3. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
4. 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.
5. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

The item on this page is optional

Answering this item is your choice. You can't be denied coverage because you don't fill it out.

Select one if you want us to send you information in an accessible format.

❑ Braille ❑ Large print ❑ Audio CD

Please contact MedicareBlue Rx at **1-866-434-2037** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., daily, Central and Mountain times. TTY users can call **711**.

PRIVACY ACT STATEMENT

Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

If you need more information

Visit **YourMedicareSolutions.com**

Call **1-866-434-2037**, 8 a.m. to 8 p.m., daily, Central and Mountain times (TTY: **711**)

Contact your certified independent agent

MedicareBlue Rx is a Medicare-approved Part D sponsor. Enrollment in MedicareBlue Rx depends on contract renewal.

MedicareBlue Rx does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities.

Please contact our Medicare Solutions specialists at the phone number above if you need information in another language or format (for example, Braille or large print).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-434-2037** (TTY: **711**).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-866-434-2037** (TTY: **711**).

Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota* and Blue Cross Blue Shield of Wyoming.*

*Independent licensees of the Blue Cross and Blue Shield Association

MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

RAS1074R13 (08/20)