2021 MedicareBlue℠ (PDP) Rx Medicare Prescription Drug Plan Individual Enrollment Form

Easy options to enroll

Enroll online at **YourMedicareSolutions.com**

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

Contact your licensed sales representative

Fill out the enrollment form and mail to:

MedicareBlue Rx
P.O. Box 3178
Scranton, PA 18505

Questions? Review the Summary of Benefits included in your 2021 MedicareBlue Rx Enrollment Guide. Or call our Medicare Solutions specialists at the phone number above or your licensed sales representative.

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

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

To join a plan, you must:

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

Important: To join a 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 join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items on page 1. The item on page 7 is optional — you can't be denied coverage because you don't fill it out.

Reminders:

- If you want to join a plan 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 join, 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**.

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MedicareBlue Rx Medicare Prescription Drug Plan Individual Enrollment form

Please contact MedicareBlue Rx if you need information in another language or format (Braille).

To enroll in MedicareBlue Rx, please provide the following information.

A. Personal information (please print clearly)

Last name: First name: Middle initial:

❑ Mr. ❑ Mrs. ❑ Ms.	❑ Male ❑ Female	Birth date: ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y
Home phone number: ( )		Alternate phone number (optional): ( )

Email address:

Permanent residence street address **(Don't enter a P.O. Box):**

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

City:	State:	ZIP code:

B. Choose your plan option (for premium information, see your Summary of Benefits)

MedicareBlue Rx: ❑ Standard ❑ Premier

C. Please provide your Medicare insurance information

Medicare number: ☐☐☐☐ – ☐☐☐ – ☐☐☐☐

Enrollee name: _____

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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. The 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.

Please select a 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: _____

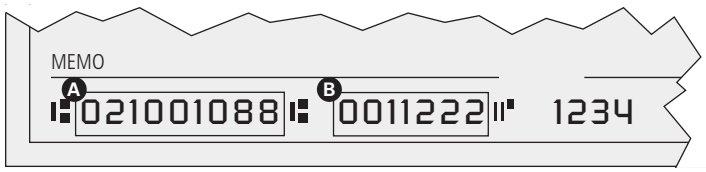
Financial institution: _____

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

Enrollee name: _____

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E. Enrollment period determination

Typically, you may enroll 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 enroll 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 dates is only allowed in the enrollment situations identified below.** In all other cases, or if you do not specify an effective date, your effective date will 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

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

❑ I am new to Medicare. My Medicare Part A effective date is ☐☐☐☐☐☐☐☐ and my Medicare Part B effective date is ☐☐☐☐☐☐☐☐.

I AM MOVING OR HAVE MOVED

❑ 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 the following date: ☐☐☐☐☐☐☐☐. Requested effective date is ☐☐☐☐☐☐☐☐ (cannot be before your move date).

❑ 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: ☐☐☐☐☐☐☐☐.

❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on the following date: ☐☐☐☐☐☐☐☐.

I LOST OR AM LOSING MY COVERAGE

❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) or was notified of the loss (whichever is later). I lost my drug coverage on the following date: ☐☐☐☐☐☐☐☐. Requested effective date is ☐☐☐☐☐☐☐☐.

❑ I am being disenrolled from a special needs plan because my condition does not qualify me for that plan as of the following date: ☐☐☐☐☐☐☐☐.

❑ I am being disenrolled from my existing plan due to its non-renewal as of the following date: ☐☐☐☐☐☐☐☐. (Note: The enrollment period for this is December 8 – February 28. Enrollments received in December, January or February are effective the first of the next month).

Enrollee name: _____

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❑ I have been disenrolled from a Medicare Advantage Prescription Drug plan due to loss of Part B but continue to be entitled to Part A as of the following date: ☐☐☐☐☐☐☐☐.

❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

❑ I am leaving employer or union coverage on the following date: ☐☐☐☐☐☐☐☐. Requested effective date is ☐☐☐☐☐☐☐☐.

❑ I am leaving my Medicare Advantage plan within 12 months of my initial enrollment under a special enrollment period to go back to a Medigap (Medicare Supplement) plan as of the following date: ☐☐☐☐☐☐☐☐.

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 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 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: ☐☐☐☐☐☐☐☐.

OTHER REASONS

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

❑ I recently obtained lawful presence status in the U.S. I got this status on the following date: ☐☐☐☐☐☐☐☐.

❑ 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 the following date: ☐☐☐☐☐☐☐☐.

❑ 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 was recently released from incarceration. I was released on the following date: ☐☐☐☐☐☐☐☐.

❑ Other special enrollment period not identified above. _____

If none of these statements apply to you or you're not sure, please contact our MedicareBlue Rx Medicare Solutions specialists (via the phone number on the front of this form) to see if you are eligible to enroll.

F. Please answer the following questions to help Medicare coordinate your benefits

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 MedicareBlue Rx? ❑ Yes ❑ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

G. Please read section H of this enrollment form and sign below

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 application, including the information in Section H. 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.

Signature: _____ **Today's date:** _____

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

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.

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

After carefully reading the statements in this section, please sign Section G 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 7).
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.

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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

The 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 licensed sales representative

MedicareBlue Rx[SM] (PDP) 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.

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[SM] Rx (PDP)
A Medicare Prescription Drug Plan

RAS1018R13 (08/20)