



Official Use Only: Date Stamp

Blue MedicareRxSM (PDP) Medicare Prescription Drug Plan 2017 Enrollment Form

Return completed applications to your Employer

Please refer to the Blue MedicareRx (PDP) Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Please contact Blue MedicareRx (PDP) if you need information in another format (Large Print)

Before you begin this application, please review the important information noted in Step 5.

Step 1: Please provide information about you. (Please print clearly.)

Group Employer Name		Requested Effective Date of Coverage	
Last Name		First Name	MI
Permanent residence street address (P.O. Box is not allowed)			
City	State	ZIP Code	
Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home phone number ()	
Mailing address (only if different from your permanent residence address)			
Street/P.O. Box	City	State	ZIP Code

Step 2: Please confirm that you qualify for Blue MedicareRx (PDP) as a Retiree or Spouse/Dependent of a Retiree.

1. I qualify for coverage under Blue MedicareRx (PDP) as a retiree of the employer or union offering me this plan. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. I qualify for coverage under Blue MedicareRx (PDP) as the spouse or dependent of the retiree. <input type="checkbox"/> Yes <input type="checkbox"/> No
Retirement date of retiree (month/date/year): ____/____/____	

Step 3: Please provide your Medicare Insurance information.

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> Please fill in the blanks at the right so they match your red, white and blue Medicare card. <p align="center">– OR –</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>		
	Name	
	Medicare Claim Number	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Is Entitled To HOSPITAL (Part A) MEDICAL (Part B)	Effective Date ____/____/____ ____/____/____

Step 4: Please answer the following questions to help Medicare coordinate your benefits.

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)

Step 5:  Please read this important information.

You may only enroll in this plan if you are a retiree or the spouse/dependent of a retiree who qualifies for this Blue MedicareRx (PDP) plan based upon prior employment with the employer or union offering this plan. This plan is not available to individuals who work enough hours to qualify to enroll in the employer health plans offered to active employees by the employer or union offering this plan.

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage as part of your Medicare Advantage plan. 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 another employer or union, joining Blue MedicareRx (PDP) could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue MedicareRx (PDP) may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Step 6: Please provide your Enrollment Period information.

Because this is a group plan, you may enroll during your group's open enrollment period. 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 and check the box(es) that apply to you. We will contact you for additional information.

I am enrolling during my former employer's Annual Open Enrollment Period.

I belong to a pharmacy assistance program provided by my state. (SEP)

I am new to Medicare or newly retired.

I get extra help paying for Medicare prescription drug coverage. (SEP)

I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums. (SEP)

I no longer qualify for extra help paying for my Medicare prescription drug coverage. (SEP)

Date I stopped receiving extra help: ____/____/____

Step 6: Please provide your Enrollment Period information. (cont.)

<input type="checkbox"/> I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or a long term care facility). (SEP) Date I moved or will move out of the facility: ____/____/____	<input type="checkbox"/> I am involuntarily losing coverage I had from an employer or union. (SEP) Attach copy of coverage termination letter.
<input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). (SEP) Date I lost my drug coverage: ____/____/____	<input type="checkbox"/> I am voluntarily leaving employer or union coverage. (SEP) Date I am leaving this coverage: ____/____/____
<input type="checkbox"/> 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. (SEP) Date of move: ____/____/____	<input type="checkbox"/> I am eligible to disenroll from my Medicare Advantage plan and enroll in a Part D plan during an MA Open Enrollment Period or during a trial period. (SEP) Provide beginning and end dates of eligibility period: Begin date: ____/____/____ End date: ____/____/____
<input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. (SEP) Date I returned to the U.S.: ____/____/____	<input type="checkbox"/> I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP) Date I left PACE: ____/____/____
<input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	<input type="checkbox"/> None of these statements applies to me.*

*If you have any questions regarding your enrollment eligibility, please contact your employer group Benefits Administrator.

Step 7: Application Agreement Important: Read this information before signing in Section 8 on back.

By completing this enrollment application, I agree to the following: Blue MedicareRx (PDP) is a Medicare Part D 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 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 my enrollment in my current plan. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan only at certain times of the year and under certain special circumstances by sending a request to my former employer.

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 do not have or obtain other Medicare prescription drug coverage or credible 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.

Step 8: Signature

I understand that my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) 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.

Authorized signature*	Today's Date ____ / ____ / ____
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If you are the authorized representative, you must sign above and provide the following information:

Name	Phone number	Relationship to enrollee	
Street/P.O. Box	City	State	ZIP Code

Applicant: Please Do Not Complete the Following Sections. For Office and Agent/Broker Use Only.

Group number	Office Use: Name/Code Number/Signature of staff member (if he/she assisted in enrollment):
Inside rep / /	Field rep / /
Plan ID#	Effective Date of Coverage ____ / ____ / ____ OR Not Eligible

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. Blue Cross and Blue Shield of Vermont is an independent licensee of the Blue Cross and Blue Shield Association.

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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 Independent Licensees of the Blue Cross and Blue Shield Association.



**BlueCross BlueShield
of Vermont**

An independent licensee of the
Blue Cross and Blue Shield Association.

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of
Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.



For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

नःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevodjenja, pozovite na broj (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電 (800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.