BlueCross BlueShield of Vermont

Official Use Only: Date Stamp

BLUE MEDICARERX[SM] (PDP)
MEDICARE PRESCRIPTION DRUG PLAN
2018 ENROLLMENT FORM

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

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.

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 _____ / _____ / _____	☐ Male ☐ 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. ☐ Yes ☐ No	2. I qualify for coverage under Blue MedicareRx (PDP) as the spouse or dependent of the retiree. ☐ Yes ☐ No

Retirement date of retiree (month/date/year): _____ / _____ / _____

STEP 3: Please provide your Medicare Insurance information.

Please take out your Medicare Card to complete this section.

- Please fill in the blanks at the right so they match your red, white and blue Medicare card.

– OR –

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

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

MEDICARE HEALTH INSURANCE

Name	
Medicare Claim Number ___ ___ ___ –___ ___ –___ ___ ___ ___ ___	☐ Male ☐ 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)? If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:	☐ Yes ☐ No

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? If "yes" please provide the following information:	☐ Yes ☐ No

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.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Open Enrollment Period (AEP) from October 15 to 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 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 (AEP).	☐ I belong to a pharmacy assistance program provided by my state. (SEP)
☐ I am new to Medicare. (Initial Enrollment Period (IEP))	☐ 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. (Special Election Period (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.)

☐ 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: _____/_____/_____	☐ I am involuntarily losing coverage I had from an employer or union. (SEP) Attach copy of coverage termination letter.
☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). (SEP) Date I lost my drug coverage: _____/_____/_____	☐ I am voluntarily leaving employer or union coverage. (SEP) Date I am leaving this coverage: _____/_____/_____
☐ 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: _____/_____/_____	☐ 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: _____/_____/_____
☐ I recently returned to the United States after living permanently outside of the U.S. (SEP) Date I returned to the U.S.: _____/_____/_____	☐ I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP) Date I left PACE: _____/_____/_____
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	☐ 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 left.

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 _____ / _____ / _____

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.

176223M 55-0928-18 (8/17)

BlueCross BlueShield of Vermont

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

S2893 VTGRP 10/2017

Nondiscrimination Notice - The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by:

- Calling 1-800-368-1019. TTY users should call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201

Notice of Availability of Auxiliary Aids & Services - We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We'll take appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

- Relay service — TTY users should call 1-877-486-2048.
- Alternate formats — This Medicare Redetermination Notice is available in alternate formats, including large print, Braille, data CD and audio CD. To request your notice in an alternate format, call
  1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Aviso sobre la discriminación - Los Centros de Servicios de Medicare y Medicaid (CMS) no excluye, niega beneficios o discrimina contra ninguna persona por motivos de raza, color, origen nacional, incapacidad, género o edad. Si cree que ha sido discriminado o tratado injustamente por cualquiera de estos motivos, puede presentar una queja ante el Departamento de Salud y Servicios Humanos, Oficina de Derechos Civiles:

- Llamando al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.
- Visitando hhs.gov/ocr/civilrights/complaints.
- Escribiendo a la: Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Ayuda y servicios auxiliares para personas con incapacidades - Medicare está dedicado a ofrecerles a todos sus beneficiarios los programas, beneficios, servicios, dependencias, información y su tecnología, en cumplimiento con las Secciones 504 y 508 de la Ley de Rehabilitación del 1973. Medicare tomará las medidas necesarias para asegurarse de que las personas incapacitadas, entre los que se incluyen los que tiene problemas auditivos, son sordos, ciegos, tienen problemas visuales u otro tipo de limitaciones, tengan las mismas oportunidades de participar y aprovechar los programas y beneficios disponibles. Medicare ofrece varios servicios y ayuda para facilitar la comunicación con las personas incapacitadas incluyendo:

- Servicios de retransmisión de mensajes — Los usuarios de TTY deben llamar al 1-877-486-2048.
- Formatos alternativos — Los productos de Medicare, incluyendo esta redeterminación, están disponible en letra grande, versión digital, Braille y audio. Para ordenar su aviso en un formato alternativo, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-MEDICARE (TTY: 1-877-486-2048).

العربية (Arabic) ملاحظة: إن كنت تتحدث لغة اخرى غير الانجليزية، فإن خدمات المساعدة اللغوية متوافرة لك بالمجان. اتصل بالرقم 1-800-MEDICARE (الهاتف النصي: 1-877-486-2048).

հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-MEDICARE (TTY (հեռատիպ)՝ 1-877-486-2048)

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-MEDICARE（TTY：1 -877-486-2048）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-MEDICARE (TTY: 1-877-486-2048) تماس بگیرید.

Français (French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-MEDICARE (ATS : 1-877-486-2048).

Kreyòl Ayisyen (French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-MEDICARE (TTY: 1-877-486-2048).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-MEDICARE (TTY: 1-877-486-2048).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-MEDICARE (TTY: 1-877-486-2048).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-MEDICARE（TTY:1-877-486-2048）まで、お電話にてご連絡ください。

한국어(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-MEDICARE (TTY: 1-877-486-2048) 번으로 전화해 주십시오.

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-MEDICARE (TTY: 1-877-486-2048).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-MEDICARE (TTY: 1-877-486-2048).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-MEDICARE (телетайп: 1-877-486-2048).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-MEDICARE (TTY: 1-877-486-2048).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-MEDICARE (TTY: 1-877-486-2048).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-MEDICARE (TTY: 1-877-486-2048).