



**BlueCross BlueShield
of Vermont**

An Independent Licensee of the Blue Cross and Blue Shield Association.

Official Use Only: Date Stamp

Blue MedicareRxSM (PDP) Medicare Prescription Drug Plan 2014 Group 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.

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Blue MedicareRx (PDP) 2014 Group Enrollment Application

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 ____/____/____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	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>		 <p>Name: _____</p> <p>Medicare Claim Number _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Is Entitled To _____ Effective Date _____</p> <p>HOSPITAL (Part A) ____/____/____</p> <p>MEDICAL (Part B) ____/____/____</p>	

Step 4: Please answer the following questions to help Medicare coordinate your benefits.	
<p>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.</p> <p>Will you have other prescription drug coverage in addition to Blue MedicareRx(PDP)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:</p> <p>Name of other coverage: _____</p> <p>ID # for this coverage: _____ Group # for this coverage: _____</p>	
<p>2. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes" please provide the following information:</p> <p>Name of Institution: _____</p> <p>Address & Phone Number of Institution (number and street): _____</p>	
Step 5: STOP Please read this important information.	
<p>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.</p> <p>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.</p> <p>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.</p>	
Step 6: Please provide your Enrollment Period information.	
<p>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.</p>	
<input type="checkbox"/> I am enrolling during my former employer's Annual Open Enrollment Period	<input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. (SEP)
<input type="checkbox"/> I am new to Medicare or newly retired.	<input type="checkbox"/> I am new to Medicare or newly retired. I get extra help paying for Medicare prescription drug coverage (SEP)

