

INSTRUCTIONS: Please complete all sections of this form. Please read each statement in Section I. Sign and date where indicated in Section G. Mail completed form to: Enrollment Services, P.O. Box 2190, Chester, VA 23831. For information, call 1-866-434-2037, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-866-456-1550).

A. Personal Information (Please print clearly):

Last Name:		First Name:		Middle Initial:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date: (mm/dd/yyyy) ____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number (optional):		Home Phone Number: ()	
Permanent Residence Street Address:							
City:		State:		ZIP Code:			
Mailing Address (only if different from your Permanent Residence Address):							
Street:		City:		State:		ZIP Code:	

B. Enroll me in the plan checked below (these are monthly premiums):

MedicareBlue Rx Option 1 - \$24.70
 MedicareBlue Rx Option 2 - \$62.50
 MedicareBlue Rx Option 3 - \$94.00

C. Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Fill in the blanks so they match your red, white and blue Medicare card exactly.
- 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.



Name: _____
 Medicare Claim Number: _____ Sex: _____

_____ - _____ - _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Medicare Prescription Drug Plan Use Only:

Office Use Only

Name of staff member (if assisted in enrollment): _____

Plan ID#: _____ Effective Date of Coverage: _____

ICEP/IEP: ____ OEP: ____ AEP: ____ SEP (type): ____ Not Eligible: ____

D. Enrollment Period Determination

Typically, you may only enroll in a Medicare Prescription Drug Plan during the annual open enrollment period between November 15 and December 31 of each year. However, 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 one box to the left of the statement. MedicareBlue Rx will contact you for additional information.

- I am enrolling during the annual open enrollment period, November 15 through December 31
- I am enrolling during the Medicare Advantage Open Enrollment Period, January 1 through March 31 (disenrolling from a Medicare Advantage Prescription Drug plan)
- I am new to Medicare. My effective date is (mm/dd/yyyy) ___ / ___ / _____
- I moved outside of my current Medicare health plan's or Medicare prescription drug plan's service area on (mm/dd/yyyy) ___ / ___ / _____
- I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums
- I receive extra help paying for Medicare prescription drug coverage as of (mm/dd/yyyy) ___ / ___ / _____
- I am no longer eligible for extra help paying for my Medicare prescription drugs as of (mm/dd/yyyy) ___ / ___ / _____
- I live in a Long Term Care Facility (for example, a nursing home or long-term care facility) as of (mm/dd/yyyy) ___ / ___ / _____
- I moved out of a Long Term Care Facility (for example, a nursing home or long-term care facility) on (mm/dd/yyyy) ___ / ___ / _____
- I left a PACE program on (mm/dd/yyyy) ___ / ___ / _____
- I involuntarily lost my coverage that is creditable prescription drug coverage (as good as Medicare's) on (mm/dd/yyyy) ___ / ___ / _____
- I am either losing coverage I had from an employer or leaving employer coverage as of (mm/dd/yyyy) ___ / ___ / _____
- I belong to a pharmacy assistance program provided by my state
- After living permanently outside the United States, I recently returned to the U.S. on (mm/dd/yyyy) ___ / ___ / _____
- I have disenrolled from a Medicare cost plan and the plan's optional supplemental Part D benefits as of (mm/dd/yyyy) ___ / ___ / _____
- Other Medicare Advantage coordinated Special Enrollment Period as of (mm/dd/yyyy) ___ / ___ / _____
- 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 plan as of (mm/dd/yyyy) ___ / ___ / _____

If none of the statements apply to you or if you are not sure, please call Customer Service at 1-866-434-2037 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-866-456-1550) to see if you are eligible to enroll.

E. Paying Your Plan Premium (also see Section I):

You can pay your monthly plan premium by mail or by Electronic Funds Transfer (EFT) each month. After your coverage takes effect, you can also choose to pay your premium by automatic deduction from your Social Security check each month. If you are interested in other payment options, please contact us at 1-888-832-0075, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: <1-888-693-3819>). If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. Generally, you must stay with the option you choose for the rest of this year. If you don't select a payment option, you will receive a bill each month. **Please select a premium payment option (do not send a payment with this application):**

- Receive a paper bill each month
- Electronic Funds Transfer (complete EFT form)*

* **If you selected EFT** as your premium payment option, please be sure to complete the EFT form included in the enrollment kit and mail it with your enrollment form. Please note that it may take up to **two months** to process your request. Please pay your premiums billed to you on paper until your EFT is active.

F. 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 MedicareBlue Rx? Yes No

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

Name of coverage: _____ ID number for this coverage: _____ Group number for this coverage: _____

If this coverage is part of a Medigap plan, you must cancel your Medigap drug coverage *after* you are enrolled in MedicareBlue Rx.

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 the Institution: _____

Address and Phone Number of Institution (number and street): _____

G. Please Read Back of Enrollment Form and Sign Below:

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application, including the information in Sections H and I. 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 MedicareBlue Rx or by Medicare.

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.

Your Signature: _____ Today's Date: _____

If you are the authorized representative, you MUST provide the following information:

Name (Print): _____ Phone Number: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Relationship to Enrollee: _____

Check if Applicant received assistance in completing this form. The person who assisted Applicant must sign below.

Assistant Signature: _____ Date: _____ Relationship to Applicant: _____

Agent Name (Print): _____ Agent #: _____ Agency #: _____

Agent Signature: _____ Date: _____ Phone Number: _____

H. STOP - Please Read This Important Information - STOP

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining MedicareBlue Rx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. 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 an employer or union, joining MedicareBlue Rx could affect your employer or union health benefits. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.

I. Enrollment Authorization: By completing this application, I agree to the following statements:

Please read carefully and sign Section G of this form after reading all statements in this section. Keep the copy marked "applicant" for your records.

1. I understand MedicareBlue Rx is a regional Medicare Prescription Drug Plan with a Medicare contract. MedicareBlue Rx coverage is provided by only one of the following plans, depending on the state in which the policy was issued: 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.*
2. I understand MedicareBlue Rx is a Medicare prescription drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform MedicareBlue Rx 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 MedicareBlue Rx will end that enrollment.
3. Enrollment in this plan is generally for the entire year. I understand I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a signed request to MedicareBlue Rx or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days per week. TTY/TDD users should call 1-877-486-2048.
4. I understand MedicareBlue Rx serves a specific service area. If I move out of the area that MedicareBlue Rx serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
5. I understand once I am a member of MedicareBlue Rx, I have the right to appeal MedicareBlue Rx decisions about payment or services if I disagree. I will read the Evidence of Coverage document from MedicareBlue Rx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
6. I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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.
7. I understand that by joining this Medicare prescription drug plan, MedicareBlue Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MedicareBlue Rx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
8. I understand that if I obtain prescriptions outside the MedicareBlue Rx network, I may be required to pay the difference between the billed and allowed amount.
9. I understand that the person discussing plan options with me is either employed by or contracted with the independent Blue Cross and Blue Shield Plans offering MedicareBlue Rx. The person may be compensated based on my enrollment in a plan.
10. For MedicareBlue Rx Option 3 applicants only: By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for in whole or in part, my enrollment in a Medicare drug plan.

*Independent licensees of the Blue Cross and Blue Shield Association

Distribution: White Copy: Carrier Yellow Copy: Applicant



2008 Individual Enrollment Form

Follow these easy steps to enroll:

1. Review the Summary of Benefits included in "Your 2008 MedicareBlue Rx Easy Enrollment Kit."
2. Contact an authorized independent agent or call one of our MedicareBlue Rx representatives to help you determine which plan is right for you.
3. Enroll by:
 - Filling out the enrollment form and returning it in the postage-paid return envelope
 - Enrolling online at www.YourMedicareSolutions.com
 - Calling MedicareBlue Rx Customer Service at 1-866-434-2037, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-866-456-1550) and we'll enroll you right over the phone.

For More Information ...

Contact your authorized independent agent

Or call MedicareBlue Rx toll-free: 1-866-434-2037

TTY/TDD users should call: 1-866-456-1550

8 a.m. to 8 p.m., daily, Central and Mountain Time

Or visit us on the Web at www.YourMedicareSolutions.com