



MedicareBlueSM Rx (PDP)

A Medicare Prescription Drug Plan

Individual Change Form

Complete this form only if you wish to change your MedicareBlue Rx plan option.

You qualify to change your plan option if you meet one of the following requirements:

- It is during the annual enrollment period, October 15 to December 7
- You qualify for Extra Help with your prescription drug costs
- You no longer qualify for Extra Help
- You meet certain special exceptions (see the Enrollment Period Determination section on the next page)

To change to a different Medicare Prescription Drug plan option with MedicareBlue Rx:

- Fill out the Change Form online at YourMedicareSolutions.com

OR

- Fill out this form
- Check the plan option you want to change to
- Sign the form
- Mail the completed form to the address below

Your coverage with the new plan option will be effective:

- If we receive your completed form by the end of any month, your new benefit plan will generally begin the first of the following month.
- Selections made during the annual enrollment period (October 15 to December 7) are effective January 1.

Questions?



Visit us online at YourMedicareSolutions.com



MedicareBlue Rx Customer Service: **1-888-832-0075**

TTY hearing impaired users call **711**

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



MedicareBlue Rx (PDP)

P.O. Box 3178

Scranton, PA 18505



Contact your independent certified agent

MedicareBlue Rx individual change form

A. Member information (please print clearly)

Last name:	First name:	Middle initial:
Member number (Printed on your MedicareBlue Rx ID card):	Medicare number (Printed on your red, white and blue Medicare ID card):	
Home phone number:	Alternate phone number (optional):	Email address (optional):
Permanent residence street address (P.O. Box is not allowed):		
City:	State:	ZIP code:

B. Plan options (for premium information, see your Summary of Benefits)

Please check the box below for the plan option you wish to change to:

MedicareBlue Rx: Standard Premier

C. Enrollment period determination

Typically, you may only enroll or change plan options in a Medicare Prescription Drug Plan during the annual enrollment period between October 15 and December 7. Additionally, there are exceptions that may allow you to change your plan option 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. Your effective date will generally be the first of the month after your form is received by the plan.

- I am enrolling during the annual enrollment period, October 15 to December 7, for **an effective date on the following January 1.** (Note: The enrollment application must be received by December 7 for the enrollment to be effective on the following January 1.)
- 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 (mm/dd/yyyy) _____.
- 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 (mm/dd/yyyy) _____.
- 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 (mm/dd/yyyy) _____.
- 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 belong to Big Sky Rx (a state pharmaceutical assistance program) provided by the state of Montana.
- Other Special Enrollment Period not identified above _____

If none of the statements apply to you or if you are not sure, please contact MedicareBlue Rx Customer Service (the phone numbers are on the front of this form) to see if you are eligible to enroll.

Distribution: White Copy: Carrier Yellow Copy: Enrollee

Enrollee name: _____

D. Paying your plan premium

You can continue your current premium payment method for next year or change it. Please select a premium payment option:


- Keep my current 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:

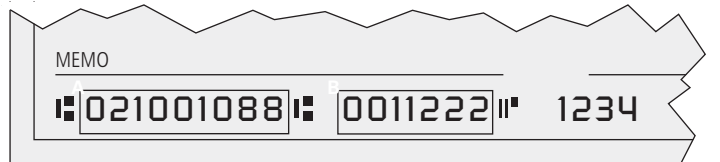
Account holder name: _____


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

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You may also choose automatic deduction from your Social Security or RRB checks after you are enrolled. If Social Security/RRB does not approve your automatic deduction request, we will send you paper bills for your monthly premiums and resubmit your request. Once approved, it can take two or more months for the deduction to begin. During this time, you will receive paper bills and be responsible for paying your premium directly to the plan until the deduction begins. If you do not pay your premium for the months before the deduction takes effect, you may be disenrolled from the plan. Neither Social Security nor RRB allow retroactive withholding requests.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or RRB check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to MedicareBlue Rx.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213**, 7 a.m. to 7 p.m., Monday - Friday. TTY users should call **1-800-325-0778**. You can also apply for Extra Help online at ssa.gov/medicare/prescriptionhelp/. 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 doesn't cover. If you don't select a payment option, you will receive a bill each month.

Please contact MedicareBlue Rx at **1-888-832-0075** if you would prefer that we send you information in a language other than English or in an accessible format. TTY users should call **711**. Our office hours are 8 a.m. to 8 p.m., daily, Central and Mountain Times.

Distribution: White Copy: Carrier Yellow Copy: Enrollee

Enrollee name: _____

E. Please read section F of change form and sign below

I want to transfer from my current plan option to the plan option I have selected here. I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this change form, including the information in Section F. 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 Medicare. The information on this change 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:** _____

I give permission to the licensed agent identified below to enter my change 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.

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

After carefully reading all statements in this section, please sign Section E of this form. Keep the copy marked "Enrollee" for your records.

1. I understand that MedicareBlue Rx (PDP) is a regional Medicare prescription drug plan and has a contract with the Federal government. 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
2. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and Blue Shield plans offering MedicareBlue Rx, he/she may be paid based on my enrollment in MedicareBlue Rx.
3. **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that MedicareBlue Rx will release my information to Medicare and other plans as 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 that follow all applicable Federal statutes and regulations.
4. I understand that beginning on the date MedicareBlue Rx coverage begins, I must get all of my prescription drug services from MedicareBlue Rx. Prescription drugs authorized by MedicareBlue Rx and contained in my MedicareBlue Rx Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor MedicareBlue Rx will pay for these services.**



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MedicareBlue Rx 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.

Please contact our Medicare Solutions specialists at the phone number above if you need information in another language or format (for example, Braille or large print).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-832-0075** (TTY: **711**).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-888-832-0075** (TTY: **711**).