Official Use Only: Date Stamp

Blue MedicareRx[SM] (PDP)
Medicare Prescription Drug Plan
2020 Enrollment Form

Return completed applications to your Employer

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

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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 MedicareRx[SM] (PDP) 2020 Enrollment Application

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

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

Group Employer Name	Requested Effective Date of Coverage _____ / _____ / _____ *The effective date of enrollment will be the first of the month following the signature date, unless a future date is requested.*

Last Name	First Name	MI

Permanent residence street address	City	State	ZIP Code

Email address	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	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 as a Retiree or Spouse/Dependent of a Retiree

1. I qualify for coverage under Blue MedicareRx as a retiree of the employer or union offering me this plan.

   ☐ Yes ☐ No

2. I qualify for coverage under Blue MedicareRx as the spouse or dependent of the retiree.

   ☐ Yes ☐ No

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

Step 3: Please provide your Medicare Insurance information.

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

  - OR -

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

Name (as it appears on your Medicare card):

_____

Medicare Claim Number

_____

Is Entitled to:	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

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

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? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this:

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 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, 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 another employer or union, joining Blue MedicareRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue MedicareRx 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.	☐	I belong to a pharmacy assistance program provided by my state.
☐	I am new to Medicare.	☐	I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on: ____/____/____
☐	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	☐	I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a

	drug coverage, but I haven't had a change. I am making this enrollment request between January 1 and September 30 and I understand I can only make this request once per quarter.		change in the level of Extra Help, or lost Extra Help) on: ____/____/____

☐	I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home). Date I moved or will move out of the facility: ____/____/____	☐	I am involuntarily losing coverage I had from an employer or union. Please attach copy of coverage termination letter.
☐	I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). Date I lost my drug coverage: ____/____/____	☐	I am voluntarily leaving employer or union coverage. 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. 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. 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. Date I returned to the U.S.: ____/____/____	☐	I recently left a Program of All-inclusive Care for the Elderly (PACE). Date I left PACE: ____/____/____
☐	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	☐	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.
		☐	None of these statements apply 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 below.

By completing this enrollment application, I agree to the following: Blue Medicare Rx 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 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 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 serves a specific service area. If I move out of the area that Blue MedicareRx 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 network pharmacies. Once I am a member of Blue MedicareRx, 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 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 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.

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 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 Address	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#:

and Effective Date of Coverage ***or*** Not Eligible

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