EmblemHealth®

EmblemHealth Medicare Prescription Drug Plan Individual Enrollment Form

Please contact EmblemHealth if you need information in another language or format.

To Enroll, Please Provide the Following Information:	
Note to Applicant: For information about service area and premiums of EmblemHealth Medicare Prescription Drug Plans available to you, please refer to the Summary of Benefits. **Please check which plan you want to enroll in:**	
☐ **EmblemHealth VIP Rx (PDP)**	☐ **EmblemHealth VIP Rx Plus (PDP)**

LAST Name:	FIRST Name:	M.I.:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ____/____/_____	Sex: ☐ M ☐ F	Home Phone Number: ( )_____-_____	Cell Phone Number: ( )_____-_____
Email Address:			
Permanent Residence Street Address (No PO Box):			
City:		State:	ZIP Code:
Mailing Address (only if different from above):			
City:		State:	ZIP Code:
Emergency Contact:	**Phone Number:**	**Relationship to You:**	

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 Number: _____ Is Entitled to: Effective Date: HOSPITAL (Part A): _____ MEDICAL (Part B): _____ You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug plan.

Print **Clear**

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86-9908-20 8/19

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or visit *emblemhealth.com/medicare* for additional payment options. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to EmblemHealth.

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. 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 **800-772-1213**. TTY users should call **800-325-0778**. You can also apply for extra help online at **socialsecurity.gov/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 get a bill each month.**

Would you like the premium for this plan deducted from your SSA or RRB monthly benefit check? ☐ Yes ☐ No

I get monthly benefits from: ☐ Social Security ☐ RRB

Please Read and Answer These Important Questions:

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 this plan? ☐ Yes ☐ No

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

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): _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ Spanish ☐ Chinese ☐ Large Print

*Please contact EmblemHealth at **800-447-9169, TTY: 711, 8 am to 8 pm, seven days a week from October 1 to March 31 and 8 am to 8 pm, Monday to Friday from April 1 to September 30, if you need information in an accessible format or language, other than what is listed above.***

Please Complete This Section To Help Determine Which Election Period You Qualify For

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period from October 15 through 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 carefully and please 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.

- ☐ I am enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7.
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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. I moved on _____/_____/_____.
- ☐ I recently was released from incarceration. I was released on _____/_____/_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____/_____/_____ .
- ☐ I recently obtained lawful presence status in the United States. I got this status on _____/_____/_____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____/_____/_____.
- ☐ 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 _____/_____/_____.
- ☐ 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 am moving into, 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 facility on_____/_____/_____.
- ☐ I recently left a PACE program on _____/_____/_____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____/_____/_____.
- ☐ I am leaving employer or union coverage on _____/_____/_____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on _____/_____/_____.
- ☐ 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 none of these statements apply to you or you're not sure, please contact EmblemHealth at **800-447-9169**, TTY: **711**, 8 am to 8 pm, 7 days a week from October 1 to March 31 and 8 am to 8 pm, Monday to Friday from April 1 to September 30, to see if you are eligible to enroll.

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining this Medicare drug plan, 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 an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union health coverage, if you join this plan. 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 isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

EmblemHealth Medicare plans are Medicare Drug plans and have 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 Part A or Part B coverage. It is my responsibility to inform you 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 this plan will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

EmblemHealth Medicare serves a specific service area. If I move out of the area that these plans serve, 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 EmblemHealth's network pharmacies. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from EmblemHealth Medicare when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with EmblemHealth, he/she may be paid based on my enrollment in an EmblemHealth Medicare plan.

I understand that the phone numbers and/or email I provided on this application may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that the EmblemHealth Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that EmblemHealth 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. 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under the State law where I live) 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 from Medicare.

Your Signature:	
Proposed Effective Date:	**Today's Date:**

Continued

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____- _____ **Relationship to Enrollee:**_____

For Company Use Only

Staff Member/Agent/Broker Signature: _____ Agent/Broker ID#: _____

Date Accepted: _____ Source Code: _____ Location: _____

Election Period: ICEP/IEP: _____ AEP: _____ SEP (type): _____

Scope of Appointment (required if not seminar): ☐ Yes Seminar ☐ No Seminar

Please fax or mail the completed form (5 pgs) to:
EmblemHealth Medicare
P.O. Box 4001
Farmington, CT 06034-9900
Fax: 1-866-890-7722

Group Health Incorporated (GHI) is a standalone PDP with a Medicare contract. Enrollment in GHI depends on contract renewal. GHI is an EmblemHealth company. ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 877-411-3625 (TTY/TDD: 711). ATENCIÓN: Si usted habla otros idiomas, tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al 877-411-3625 (TTY/TDD: 711).