OMB No. 0938-1378
Expires: 7/31/2023

EmblemHealth®

Individual Enrollment Request Form to Enroll in a Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Emblemhealth Medicare
PO BOX 4001
Farmington CT 06034-9900

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call EmblemHealth at **800-447-9169**.
TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE** (1-800-633-4227). TTY users can call **1-877-486-2048**.

En español: Llame a EmblemHealth al **800-447-5496**/TTY: **711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

S5966_201343_C Approved 8/21/2020

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EmblemHealth Medicare Prescription Drug Plan Individual Enrollment Form

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

Section 1 - 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:		**Contact Preference:** ☐ Mail ☐ Email ☐ Text ☐ Phone	
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:**	
Medicare Number _____ **Part A** ___/____/_____ **Part B** ___/____/_____			

Will you have other prescription drug coverage in addition to this plan? ☐ Yes ☐ No

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

Are you enrolled in your State Medicaid program? ***(Required for enrollment in SNP Plans)** ☐ Yes ☐ No
If "yes," please provide your Medicaid number: _____

Print Clear

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86-9908-21 8/20

Please Read and Sign Below

- I must keep Part A or Part B to stay in EmblemHealth Medicare Prescription Drug Plans.
- By joining this Medicare Prescription Drug Plan, I acknowledge that EmblemHealth Medicare will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to Federal statutes that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Your Signature:

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

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

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

Section 2

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or 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 pay 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 benefit check or be billed directly by Medicare or RRB. DO NOT pay EmblemHealth the Part D-IRMAA.

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 choose the name of a Primary Care Physician (PCP) from our Provider Directory.

Name _____ PCP #_____ ☐ Current Patient

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 the 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.

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

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.