EmblemHealth®

EmblemHealth Medicare Prescription Drug Plan (PDP) Individual Enrollment Form
Please contact EmblemHealth Medicare Prescription Drug Plan (PDP)
if you need information in another language or format (Braille).

To Enroll in EmblemHealth Medicare PDP, Please Provide the Following Information:

☐ **EmblemHealth Medicare Prescription Drug Plan (PDP) – $50.00 per month**

Last Name:	First Name:	Middle Initial ☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ____/____/_____	Sex: ☐ M ☐ F	Home Phone Number: ( ) _____-_____
Permanent Resident Street Address (PO Box is not allowed):		
City:	State:	ZIP Code:
Mailing Address (only if different from Permanent Residence Address): Street Address:	City:	State: ZIP Code:
Emergency Contact:	**Phone Number:**	**Relationship to you:**
E-mail Address:		

Please Provide Your Medicare Insurance Information

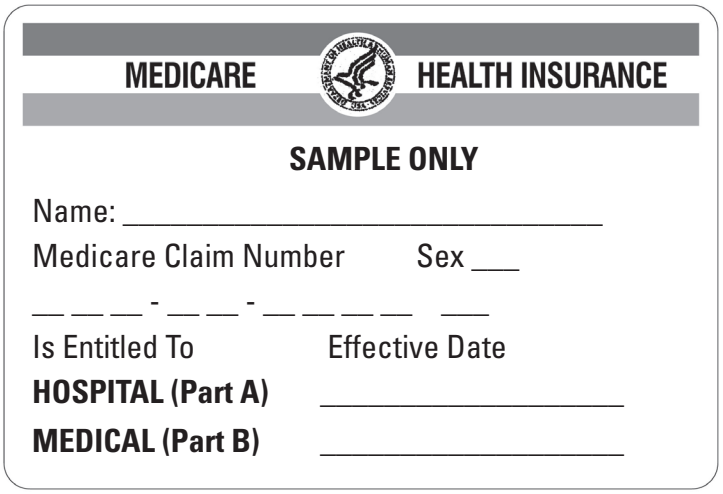
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

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

You must have Medicare Part A or Part B or both to join a Medicare Prescription Drug Plan.



This plan is underwritten by Group Health Incorporated (GHI). GHI is an EmblemHealth company.

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Paying Your Plan Premium

You can pay the monthly premium (including any late enrollment penalty that 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 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 Medicare Prescription Drug Plan.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% of 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 **1-800-772-1213**. TTY users should call **711**. You can also apply for extra help online at **www.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 receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank Account Number: _____

Account type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (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.*)

Please Answer The Following 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 and 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 another format: ☐ Spanish ☐ Chinese ☐ Large Print

*Please contact Medicare Prescription Drug Plan (PDP) at **1-877-444-7097** if you need information in another format or language than what is listed above. TTY users should call **711**. Our office hours are from 8 am to 8 pm, 7 days a week (TTY users from 8 am to 8 pm, 7 days a week).*

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period between October 15 through December 7 of each year. Additionaly, 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 new to Medicare.
- ☐ 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 returned to the United States after living permantently outside of the U.S. I returned to the U.S on _____/_____/_____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on _____/_____/_____
- ☐ 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 _____/_____/_____
- ☐ I recently left a PACE program on _____/_____/_____
- ☐ I recently involuntarily lost my creditable prescription drug 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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on _____/_____/_____.

If none of these statements applies to you or you're not sure, please contact EmblemHealth Medicare PDP at **1-877-444-7097** to see if you are eligible to enroll. We are open 7 days a week, from 8 am to 8 pm. TTY users should call **711**.

STOP 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 EmblemHealth Medicare PDP, 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 EmblemHealth Medicare PDP, could affect your employer or union health benefits. You could lose your employer or union health coverage if you join EmblemHealth Medicare Prescription Drug Plan (PDP). 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 on Reverse

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

Group Health Incorporated/EmblemHealth Medicare PDP is a Medicare 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 Part A or Part B coverage. It is my responsibility to inform EmblemHealth Medicare Prescription Drug Plan (PDP) 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 EmblemHealth Medicare Prescription Drug Plan (PDP) 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 PDP serves a specific service area. If I move out of the area that EmblemHealth Medicare PDP 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 EmblemHealth Medicare PDP network pharmacies. Once I am a member of EmblemHealth Medicare PDP, 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 Prescription Drug Plan (PDP) 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 Medicare PDP, he/she may be paid based on my enrollment in EmblemHealth Medicare PDP.

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 EmblemHealth Medicare PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that EmblemHealth Medicare PDP 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 by Medicare.

Signature:	**Today's Date:**

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

Name: _____

Address: _____

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

Medicare Prescription Drug Plan Use Only

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Name of Plan Representative/agent/broker: _____

Group Health Incorporated (GHI) is a standalone PDP with a Medicare contract. Enrollment in GHI depends on contract renewal. GHI is an EmblemHealth company.

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York (HIPIC) and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.