

Former Employer Complete This Section

Company Name:	Group Number:
Employer's Signature:	Effective Date:



BLUERX MEDICARE PRESCRIPTION DRUG PLAN GROUP ENROLLMENT FORM

To enroll in BlueRx, Please Provide the following Information:

LAST Name	FIRST Name	Middle Initial	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Birth Date (M M / D D / Y Y Y Y)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (providing this information is optional)	Home Phone Number ()		
Permanent Residence Street Address		City	State	Zip Code	
Mailing Address (only if different from your Permanent Residence Address):					
Street Address		City	State	Zip Code	

Emergency Contact: _____
Phone Number: _____ **Relationship to You:** _____

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 the Social Security Administration or Railroad Retirement Board.
 You must have Medicare Parts A or B (or both) to join a Medicare Prescription Drug Plan.

Medicare	Health Insurance
SOCIAL SECURITY ACT	
Name _____	
Medicare Claim Number _____	Sex _____
Is Entitled To _____	Effective Date _____
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

Please Answer the Following Questions to Help Medicare Coordinate Your Benefits

- 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 BlueRx? 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: _____
- 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): _____

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 a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining BlueRx, 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.

Please Read and Sign Below

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

BlueRx is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform BlueRx 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to BlueRx or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

BlueRx serves a specific area. If I move out of the area that BlueRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BlueRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueRx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that BlueRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) 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 BlueRx or by Medicare.

Your Signature: _____ **Today's Date:** _____

If you are the authorized representative, you must 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): _____

Plan Representative Signature: _____