BlueRx℠
A Medicare Approved Part D Plan

APPLICATION | **FOR OFFICE USE ONLY** ☐☐☐☐☐☐☐☐☐☐

BlueRx (PDP) Medicare Prescription Drug Plan Individual Enrollment Form

Be sure to read the important disclosures listed on the back before completing this application. Please use black ink and print clearly. Please contact BlueRx (PDP) if you need information in another language or format (Braille).

To Enroll in BlueRx (PDP), Please Provide the Following Information:

Please check which plan you want to enroll in:	☐ **BlueRx Essential (PDP)** $43.20 Per Month	☐ **BlueRx Enhanced (PDP)** $85.80 Per Month	☐ **BlueRx Enhanced Plus (PDP)** $126.70 Per Month

Personal Information

☐ Mr. ☐ Mrs. ☐ Ms.	LAST Name:	FIRST Name:	MIDDLE Initial

Permanent Residence Street Address (P.O. Box is not allowed):

County	City	State	Zip

Mailing Address (Only if different from Permanent Residence Address):

County	City	State	Zip

Date of Birth ☐☐ – ☐☐ – ☐☐☐☐	Home Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐
Sex (check one) ☐ Male ☐ Female	E-Mail Address (Optional)

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:	HOSPITAL (Part A) Effective Date:	MEDICAL (Part B) Effective Date:

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

Paying Your Plan Premium - You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, E-Checking or debit card 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 BlueRx (PDP).

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 1-800-772-1213. TTY users should call 1-800-325-0778. 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.

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Please select a premium payment option:

☐ **Get A Monthly Statement –** You will receive a billing statement each month for your plan premium.

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

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB 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 BlueRx (PDP)? ☐ 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 the box if you would prefer us to send you information in a language other than English or in another format:

☐ **Large print**

Please contact BlueRx (PDP) **Member Services**, at **1-800-327-3998 (AL), 1-888-311-7508 (TN)** if you need information in an accessible format or language other than what is listed above. **TTY users should call 711. Our office hours are 8 a.m. to 8 p.m., seven (7) days a week.** From April 1 to September 30, on weekends and holidays you may be required to leave a message. Calls will be returned the next business day.

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 BlueRx (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 BlueRx (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueRx (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 any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

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

BlueRx (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 B coverage. It is my responsibility to inform BlueRx (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 BlueRx (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.

BlueRx (PDP) serves a specific service area. If I move out of the area that BlueRx (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 BlueRx (PDP) network pharmacies. Once I am a member of BlueRx (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 BlueRx (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 BlueRx (PDP), he/she may be paid based on my enrollment in BlueRx (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 BlueRx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueRx (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 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.

Signature

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:

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Medicare Prescription Drug Plan Use Only:				
Name of Plan Representative/agent/broker:				
Plan ID #:		Effective Date of Coverage:		CY2020
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:	NIPR#:
Name of Broker Organization:				

Agent Use			
Representative Code #1: _____		**Representative Signature:** _____	**Date Received:** _____
Representative Code #2: _____		**Representative Signature:** _____	**Date Received:** _____

Mail this application in the return envelope that is included in your packet, or send to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing
P.O. Box 2768
Birmingham, Alabama 35202-2768
Fax Number: 1-888-246-0230

For more recent information or other questions, please contact **BlueRx (PDP) at 1-800-327-3998 (AL)** or **1-888-311-7508 (TN)** or, for **TTY users, 711**, **8 a.m. to 8 p.m., seven (7) days a week.** From April 1 to September 30, on weekends and holidays you may be required to leave a message. Calls will be returned the next business day or visit **www.bluerxalatenn.com.**

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BlueRx (PDP) is a Part D plan with a Medicare contract. Enrollment in BlueRx (PDP) depends on contract renewal.

BlueRx (PDP) is provided by Blue Cross and Blue Shield of Alabama and UTIC Insurance Company, independent licensees of the Blue Cross and Blue Shield Association.