

Enrollment checklist

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between November 15 and December 31 of this 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 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 (insert date) ___/___/___
- I recently retired. I retired on (insert date) ___/___/___ (optional)
- 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 drug coverage. I stopped receiving extra help on (insert date) ___/___/___
- I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) ___/___/___
- I recently left a PACE program on (insert date) ___/___/___
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ___/___/___
- I am leaving employer or union coverage on (insert date) ___/___/___
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ___/___/___
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- None of these statements applies to me. Please contact Priority Health Medicare toll-free at 888 389-6676 to see if you are eligible to enroll. TTY/TDD users should call toll-free at 888 551-6761. We are available 24 hours a day, 7 days a week.

Signature: _____ Date: _____

Enrollment instructions

To avoid delays in processing your enrollment, please follow these helpful tips.

Make sure to complete the entire enrollment form. Please check the appropriate box for the plan you wish to join. Don't forget to sign the form.

Instead of filling in the box at the bottom of page 1, you may simply attach a photocopy of your Medicare card as proof that you have Medicare Parts A and/or B coverage.

There are three options available for paying your plan premium. Please check the appropriate box on the enrollment form of the payment option you would like to use.

They are:

- You can receive a bill monthly from Priority Health and you pay the plan directly by mail
- Electronic Fund Transfer (EFT) from your bank account
 - please attach a voided check or a letter from your financial institution
- Automatic deduction from your monthly Social Security check

Enrollment form checklist:

Did you:

- Check the appropriate box for the plan you wish to join.
- Complete your Medicare Insurance information or attach a photocopy of your Medicare card as proof that you have Medicare Parts A and/or B coverage.
- Choose a premium payment option.
- Include a voided check if you chose to pay your premiums by EFT.
- Answer all questions on page 2 of the form.
- Sign and date the form.

Mail your completed enrollment form in the enclosed postage-paid reply envelope. Or, if you do not have a postage-paid reply envelope, you can send your completed enrollment form to Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525.

The Pharmacy Directory and Formulary are available on *prioritymedicare.com*.

After we receive your enrollment form, you will receive a call to verify you understand the rules and benefits associated with the plan you are enrolling in.

If you have any questions regarding enrolling in **PriorityMedicare Rx**, please call our Medicare Specialists at 616 464-8850, toll-free 888 389-6676. TTY/TDD users should call 616 464-8485, toll-free 888 551-6761. We are available 24 hours/day, 7 days/week.

PriorityMedicare RxSM (PDP) Medicare Prescription Drug Plan Individual Enrollment



Office use only	Agent use only
Subscriber ID: _____	Referring agent: <u>Michael A Kerr</u>
Effective date of coverage: _____	Referring agent #: <u>B-00844</u>
IEP / AEP / SEP (type): _____	Agent received application on: _____
PBP ID: _____	Scope of appointment included: <input type="checkbox"/> Yes <input type="checkbox"/> No
Not eligible: _____	
Processing rep: _____ Date processed: ____/____/____	

To enroll in PriorityMedicare Rx , please provide the following information:

Please check which plan you want to enroll in:

PriorityMedicare Rx

Last name		First name		M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date ____/____/____ MM DD YYYY	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ()		Alternate phone number ()	
Permanent residence street address (P.O. Box is not allowed)					
City		County	State	ZIP code	
Mailing address (only if different from your permanent residence address)					
City			State	ZIP code	
Email address					

Please provide your Medicare insurance information

<p>Please refer to your Medicare Card to complete this section.</p> <p>Please fill in these blanks so they match your red, white and blue Medicare card</p> <p>– OR –</p> <p>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</p> <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<p>Name _____</p> <p>Medicare claim number _____</p> <p>Sex _____</p> <p>Is entitled to _____ Effective date _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>
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Paying your plan premium

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to one hundred (100) percent 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 [socialsecurity.gov/prescriptionhelp](https://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.

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a bill monthly and pay the plan directly by mail.
- Electronic funds transfer (EFT) from your bank account each month.
You must enclose a VOIDED check, otherwise you will be billed directly for your monthly premium.
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

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 **PriorityMedicare Rx**? 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): _____

If you would prefer us to send you information in another format or language (like Braille or large print), please contact **PriorityMedicare Rx** at toll-free 888 389-6648 (TTY/TDD users should call toll-free 888 551-6761), our office hours are 24 hours a day, 7 days a week.

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 **PriorityMedicare Rx**, 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 **PriorityMedicare Rx** could affect your employer or union health benefits. You could lose your employer or union health coverage if you join **PriorityMedicare Rx**. 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: PriorityMedicare Rx 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 **PriorityMedicare Rx** 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 **PriorityMedicare Rx** 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 (November 15 – December 31), unless I qualify for certain special circumstances.

PriorityMedicare Rx serves a specific service area. If I move out of the area that **PriorityMedicare Rx** 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 **PriorityMedicare Rx** network pharmacies. Once I am a member of **PriorityMedicare Rx**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **PriorityMedicare Rx** 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 **PriorityMedicare Rx**, he/she may be paid based on my enrollment in **PriorityMedicare Rx**.

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 **PriorityMedicare Rx** will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that **PriorityMedicare Rx** 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 by **PriorityMedicare Rx** or 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: _____

