



Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

PO Box 12625
Salem, OR 97309-0625
1-888-REGENCE
1-888-734-3623 Fax number 1-888-335-2988
TTY 711

Regence Medicare Script™ (PDP)
Medicare Prescription Drug Plan
Individual Enrollment Form

Please contact Regence Medicare Script if you need information in another format (Braille).

To enroll in Regence Medicare Script, please provide the following information:

Please check which plan you want to enroll in:

- Regence Medicare Script Basic \$74.00
Regence Medicare Script Enhanced \$106.00

Form with fields for: LAST Name, FIRST Name, Middle Initial, Birthdate, Sex, Home Phone Number, Alternate Phone Number, Permanent Residence Street Address, City, State, ZIP Code, Mailing Address, 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.

Medicare Health Insurance card template with fields for Name, Medicare Claim Number, Sex, Is Entitled To (HOSPITAL Part A, MEDICAL Part B), Effective Date.



Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty 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 Regence Medicare Script.

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.

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 premium 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 question:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

1. Will you have other prescription drug coverage in addition to Regence Medicare Script?

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 **one** of the boxes below if you would prefer us to send your information in another format:

Large print CD Audio Tape

Please contact Regence Medicare Script at 1-800-541-8981 if you need information in another format. TTY users should call 711. Our office hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 15 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.

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 Regence Medicare Script, 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 Regence Medicare Script could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Regence Medicare Script. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.



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 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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____
- 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 or long term care facility). 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 (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.
- 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 (insert date)_____

If none of these statements applies to you or you're not sure, please contact Regence Medicare Script at 1-800-541-8981 to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 15 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.



Please read and sign below

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

Regence Life and Health Medicare Script 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 Regence Medicare Script 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 Regence Medicare Script 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.

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

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

Signature: _____ 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 (____) _____



Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Agent Name _____ Agent Number _____

Agent Phone Number (including area code) _____

Agent Signature  _____

