



B-2A

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**4. PLEASE SELECT YOUR PREMIUM PAYMENT OPTION**

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**IMPORTANT NOTE:**

**If you are eligible for, or enrolled in, a state (MD or DE) prescription drug assistance program where you receive extra help to pay your premiums, DO NOT select the SSA Withhold Option. If you check yes, the full premium will be deducted from your SSA benefit check.**

I would like this premium for this plan deducted from my SSA monthly benefit check.  Yes  No

**5. PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS:**

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 Medi-CareFirst BlueCross BlueShield?  Yes  No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:

[Grid for Name of other coverage]

ID # for this coverage:

[Grid for ID # for this coverage]

Group # for this coverage:

[Grid for 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:

[Grid for Name of Institution]

Address

[Grid for Address]

City:

[Grid for City]

State:

[Grid for State]

Zip Code:

[Grid for Zip Code]

Phone Number:

[Grid for Phone Number]

**6. STOP - PLEASE READ THIS IMPORTANT INFORMATION:**

- **If you are in 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 Medi-CareFirst BlueCross BlueShield, 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.
- **If you currently have health coverage from an employer or union, joining this Medi-CareFirst BlueCross BlueShield Medicare drug plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Medi-CareFirst BlueCross BlueShield may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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**7. PLEASE READ AND SIGN BELOW:**

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

Medi-CareFirst BlueCross BlueShield 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 Medi-CareFirst BlueCross BlueShield 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 Medi-CareFirst BlueCross BlueShield or by calling 1-800-MEDICARE. TTY/TDD users should call 1-877-486-2048.

Medi-CareFirst BlueCross BlueShield serves a specific service area (MD, D.C., DE). If I move out of the area that Medi-CareFirst BlueCross BlueShield 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 Medi-CareFirst BlueCross BlueShield, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medi-CareFirst BlueCross BlueShield when I receive it to know which rules I must follow in order to receive coverage with this Medicare prescription drug plan.

**Release of Information:**

By joining this Medicare prescription drug plan, I acknowledge that Medi-CareFirst BlueCross BlueShield 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 Medi-CareFirst BlueCross BlueShield or by Medicare.

Your Signature:

Today's Date:

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

LAST Name  FIRST Name  MI

Address:

City:  State:  Zip Code:

Phone Number:  -  Relationship to Enrollee:

**Medicare Prescription Drug Plan Use Only:**

Plan ID #:  Effective Date of Coverage:  IEP:  AEP:  SEP:

Plan Representative Signature:



Medi-CareFirst BlueCross BlueShield contracts with the Federal government to provide Medicare Prescription Drug Coverage.

**PLEASE KEEP YELLOW COPY FOR YOUR RECORDS**

Instructions Located on Back of this Application

## MARKING INSTRUCTIONS

- Please **print clearly** and **press hard**.
- Use blue or black ink only.
- Completely fill the ovals.

Correct Mark



Incorrect Marks



- Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown:

T  
S M I ~~X~~ H

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

1 0 2 4 2 0 0 6

Fields Must  
Be Completed



Fields Must Be  
Completed (If Applicable)

