

Important Information About Your Online Enrollment

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 this plan, 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 this plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this prescription drug plan. 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.

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

This prescription drug plan 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 my plan 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 this prescription drug plan 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.

This plan serves a specific service area. If I move out of the area that this plan serves, I need to notify this 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 plan network pharmacies. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the documents that I receive from this plan so that I understand 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 this plan, he/she may be paid based on my enrollment in this plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that this plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that this plan 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 this plan.

I understand that my submission (or the submission of the person authorized to act on my behalf under State law where I live) of this application means that I have read and understand the contents of this application. If submitted by an authorized individual (as described above) this submission 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.

To Any Legal Authorized Representatives:

I understand that I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the State where the individual resides. My agreement on this application means that I have read and understand the contents of this application and certifies that: 1) I am authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by the plan or by Medicare. Please click the "Agree/Submit Enrollment " button below to continue.