

Medi-CareFirst BlueCross BlueShield
Membership Customer Service
c/o CGI, Inc.
P.O. Box 2668
Fort Worth, TX 76113



Attestation of Eligibility for an Enrollment Period

Name: _____

Medicare Claim Number (HIC): _____

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) _____.

- Please turn the page -

S5766_MCF1020_SpecEnrollPdChklst11 File & Use 9/18/2011

- 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 Medi-CareFirst BlueCross BlueShield at (888) 857-6118 to see if you are eligible to enroll. We are open (October 15 to February 14): 8 a.m. to 8 p.m., 7 days a week; (February 15 to October 14): 8 a.m. to 8 p.m., Monday through Saturday. TTY/TDD users should call (800) 855-2880.

Signature: _____ Date: _____