

Mail To:
 Medicare Prescription Drug Plan
 Enrollment Center, c/o CGI
 P.O. Box 2668, Fort Worth, TX 76113

MEDICARE PRESCRIPTION DRUG PLAN CHANGE FORM

Member ID Number (As shown on your Medi-CareFirst Prescription Drug Card)

1. PLEASE SELECT YOUR PLAN (Check one)

I am currently enrolled in: BlueRx Standard (PDP) (\$84.60) BlueRx Enhanced (PDP) (\$133.40)
 I would like to enroll in: BlueRx Standard (PDP) (\$87.10) BlueRx Enhanced (PDP) (\$131.80)

LAST Name	FIRST Name	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: () -
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Permanent Residence Street Address (Is this a new address? Yes No) (P.O. Box is not allowed)

City:	State:	Zip Code:
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Mailing Address (Only if different from your Permanent Residence Address):

City:	State:	Zip Code:
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Please take out your Medicare Card and use it to indicate your Medicare Claim Number below:

- Your Medicare Claim Number ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____
- OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, or by 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 benefits check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), 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. DON'T pay Medi-CareFirst the Part D-IRMAA extra amount.

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 qualify 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.

Please turn to the back to select a payment option.

4. PAYING YOUR PLAN PREMIUM (CONTINUED)

If you don't select a payment option, you will get a bill each month. **Please select a premium payment option below:**

- Get a bill (monthly)
- Electronic Funds Transfer (EFT) from your bank account each month. To request an Electronic Funds Transfer (Easy Pay) form, call Membership Customer Service at (888) 857-6118 (TTY/TDD: (800) 855-2880), (February 15 to October 14): 8 a.m. to 8 p.m. Monday through Saturday; (October 15 to February 14): 8 a.m. to 8 p.m., 7 days a week.

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 Social Security/Railroad Retirement Board withhold option below. If you check yes, the full premium will be deducted from your Social Security/Railroad Retirement Board benefit check.

- 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 premiums 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.)

- Check here if you would prefer to receive any of these materials in large print.

Please contact Medi-CareFirst at (888) 857-6118 if you need information in another format than what is listed above. TTY users should call (800) 855-2880. Our office hours are (February 15 to October 14): 8 a.m. to 8 p.m. Monday through Saturday; (October 15 to February 14): 8 a.m. to 8 p.m., 7 days a week.

Medi-CareFirst BlueCross BlueShield (Medi-CareFirst) is a Medicare prescription drug plan and has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, or other individual employed by or contracted with Medi-CareFirst, he/she may be compensated based on my enrollment in Medi-CareFirst.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that the Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medi-CareFirst 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Medi-CareFirst coverage begins, I must get all of my prescription drug services from Medi-CareFirst. Prescription drugs authorized by Medi-CareFirst and contained in my Medi-CareFirst Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDI-CAREFIRST WILL PAY FOR THE SERVICES.**

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 Medicare.

Your Signature or Authorized Signature:	Today's Date:
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If you are the authorized representative, you must sign above and provide the following information:

Name:	Phone Number: () -
Address:	Relationship to Enrollee:



A Medicare-approved Part D sponsor.