



#### 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), 8 a.m. to 8 p.m. daily.

**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 below. If you check yes, the full premium will be deducted from your Social Security benefit check.**

- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

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

Please contact Medi-CareFirst at 888-784-0790 if you need information in another format than what is listed above. TTY users should call 888-784-0868. Our office hours are 8 am. - 8 p.m., 7 days a week.

#### 5. PLEASE READ AND SIGN BELOW:

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 Medi-CareFirst or by Medicare.

Your Signature or  
Authorized Signature:

Today's  
Date:

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

Name:

Phone Number: (     )     -

Address:

Relationship to Enrollee:

##### Medicare Prescription Drug Plan Use Only:

Plan ID #:

Effective Date of Coverage:     /     /

IEP:

AEP:

SEP (type):

Plan Representative Signature:

