



Medicare Prescription Drug Plan Enrollment Center c/o CGI
P.O. Box 8100 • Lancaster, SC 29720

MEDI-CAREFIRST RX MEDICARE PRESCRIPTION DRUG PLAN ENROLLMENT FORM

OFFICE USE ONLY:

GROUP #:

MAIL TO:
5965 SANDY RIDGE
ELKRIDGE, MD 21075

OR FAX: to 1-877-877-5801

1. PLEASE PROVIDE INFORMATION ABOUT YOU (Please print clearly)

LAST Name		FIRST Name	Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: _ / _ / _ _ _ _ M M D D Y Y Y Y	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number : _ - _ (providing this information is optional)	Home Phone Number: ()	
Permanent Residence Street Address:				
City:		State:	Zip Code:	
Mailing Address (only if different from your Permanent Residence Address):				
Street Address:		City:	State:	Zip Code:

2. PLEASE SELECT YOUR PLAN (Check one)

I would like to enroll in:

- Medi-CareFirst Rx \$0 Deductible Plan** **Medi-CareFirst Rx \$250 Deductible Plan**

3. PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

Name: _____

Medicare Claim Number _____ Sex ____

_____ - _____ - _____

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:			
Sub-Agent/Sub-Agency:			
Writing Agent:			

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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.

I would like this premium for this plan deducted from your 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 Rx? Yes No

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

Name of other coverage: _____

ID # for this coverage: _____ 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: _____

Address & Phone Number of Institution (number and street): _____

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 Rx, 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 Rx Medicare drug plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Medi-CareFirst Rx 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.

7. PLEASE READ AND SIGN BELOW:

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

Medi-CareFirst Rx 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 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 or by calling 1-800-Medicare. TTY/TDD users should call 1-877-486-2048.

Medi-CareFirst serves a specific service area. If I move out of the area that Medi-CareFirst 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 Rx, 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 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 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 or by Medicare.

Your Signature: _____	Today's Date: _____
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If you are the authorized representative, you must provide the following information:

Name : _____ Address: _____

Phone Number: (____) ____-____ Relationship to Enrollee _____

Medicare Prescription Drug Plan Use Only:

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative Signature: _____



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