TEAR HERE

AARP® | MedicareRx Plans
insured through UnitedHealthcare

AARP® MedicareRx PLANS
MEDICARE PRESCRIPTION DRUG PLAN
INDIVIDUAL ENROLLMENT FORM

Please contact AARP® MedicareRx if you need information in another language or format (Braille).

1. To enroll in one of the AARP MedicareRx plans, please provide the following information:

- ☐ AARP MedicareRx Saver Plus (PDP)
- ☐ AARP MedicareRx Preferred (PDP)
- ☐ AARP MedicareRx Enhanced (PDP)

2. Applicant Information (please type or print in black or blue ink)

☐ Mr. ☐ Mrs. ☐ Ms.

Last Name | First Name | Middle Initial

Birth Date
M M / D D / Y Y Y Y

Sex
☐Male ☐Female

Home Phone Number
( ) -

Alternative Phone Number
( ) -

Permanent Residence Street Address (P.O. Box not allowed) | Apt

City | State | ZIP Code - | County

Mailing Address (only if different from your Permanent Residence Street Address; P.O. Box is allowed for mailing address only)

City | State | ZIP Code -

Email Address (optional): Please email me plan information and updates.

TEAR HERE

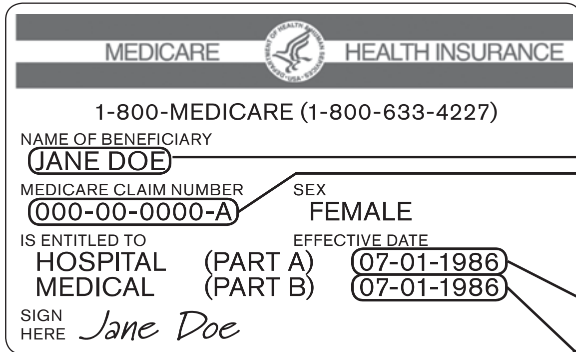
Enrollee Name:____

This page intentionally left blank.

TEAR HERE

3. Please Provide your Medicare Insurance Information

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan. Please take out your red, white and blue Medicare card to complete this section.
Please fill in these blanks so they match your Medicare card **-or-**Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as it appears on Medicare card)

Medicare Claim Number Letters (s)

Sex: ☐ Male ☐ Female

Part A (Hospital) effective date
M M / D D / Y Y Y Y

Part B (Medical) effective date
M M / D D / Y Y Y Y

An incorrect or incomplete Medicare claim number may cause a delay or denial of coverage.

4. Please answer the following questions:

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 an AARP® MedicareRx plan? ☐ **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 Number for coverage

Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If **"yes,"** Name of institution

Address of institution

City State ZIP Code -

Phone Number of institution
( ) -

Date of admission to the institution
M M / D D / Y Y Y Y

TEAR HERE

Enrollee Name:______________________________

This page intentionally left blank.

TEAR HERE

5. Your plan premium payment options:

Please select one monthly payment option by checking the appropriate box. If you select the Electronic Funds Transfer option, please include the requested information:
You have three options for paying your monthly premium (including any late enrollment penalty you may owe). You can have the monthly premium for this Medicare prescription drug plan automatically deducted from your Social Security or Railroad Retirement Board benefit check, automatically deducted from your checking or savings account through automatic debit, also known as Electronic Funds Transfer (EFT), or you can make your premium payments through a payment coupon book. If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 benefits check or be billed directly by Medicare. **Do NOT pay the Part D-IRMAA extra amount to AARP® MedicareRx Plans.**

If you do not select a payment option, you will receive a payment coupon book.

Please select a premium payment option (choose only one):

☐ **Payment coupon book for monthly payments by check.**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a **voided** check or provide the following information:

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name

Bank Routing Number

Bank Account Number

☐ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.** *(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. 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 payment coupon book for your monthly premiums).*

TEAR HERE

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late-enrollment penalty. Many people are eligible 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 Medicare doesn't cover.

Enrollee Name:______________________________

This page intentionally left blank.

TEAR HERE

TEAR HERE

6. Alternative formats (check only one):

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format if available:

☐**Spanish** ☐ **Large Print**

Please contact Customer Service at 1-888-867-5575 if you need information in another format or language than what is listed above. TTY users should call **711**. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

STOP Please read this important information.

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 one of the AARP® MedicareRx Plans, 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 a plan sponsor (former employer, union, or trust administrator), you could lose your employer or union health coverage if you join an AARP® MedicareRx Plan. Even if your group coverage is with our organization, your enrollment in an individual prescription drug plan could affect or terminate your plan sponsor coverage. In some cases, you may not be able to have your group coverage reinstated. To avoid potential disruption of your current plan coverage, 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.

7. Read and sign below:

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

This is a Medicare Prescription Drug Plan that has a contract with the Federal Government. This is not a Medicare Supplement plan. This prescription drug coverage is in addition to your coverage under Medicare; therefore, you will need to keep your Medicare Parts A and B coverage. You can only be enrolled in one Medicare Prescription Drug Plan at a time. Enrollment in this plan will automatically end your enrollment in another Medicare prescription drug plan.

If you have prescription drug coverage, or receive any in the future from somewhere other than this plan, it is your responsibility to let us know. Enrollment in this plan is generally for the entire year. You can only leave or change this plan during Medicare's open enrollment period of October 15th -December 7th, or under special circumstances.

This plan only covers the area that you live in. If you are planning to move out of the area, please call us and we will help you find a plan in your new area.

You have the right to appeal plan decisions about payment or services if you disagree. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage as good as Medicare's, you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

Enrollee Name:____

This page intentionally left blank.

If a licensed sales agent helped you choose a plan, the licensed sales agent may receive compensation based on you enrolling in the plan. Counseling services may be available in your state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use AARP® MedicareRx network pharmacies. To make yourself familiar with the services, terms and conditions of the plan, please read the Evidence of Coverage document when you receive it or you can view it online.

TEAR HERE

Release of Information:
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 my information will be released to Medicare, only as necessary, for treatment, payment and health care operations; and that AARP MedicareRx may also release my information, to Medicare, including my prescription event data, for research and other purposes which follow all applicable Federal statutes and regulations.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) 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.

Signature of applicant/member/authorized representative

Today's Date
M M / D D / Y Y Y Y

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

Last Name

First Name

Address

TEAR HERE

City

State

Zip Code
-

Phone Number
( ) -

Relationship to Applicant

Enrollee Name:____

This page intentionally left blank.

TEAR HERE

9. For broker or licensed sales agent use only:

Licensed Sales Agent Signature

Today's Date
M M / D D / Y Y Y Y

Licensed Sales Agent Name

Licensed Sales Agent ID

Licensed Sales Agent Organization

Effective Date of Coverage
M M / D D / Y Y Y Y

☐ AEP ☐ IEP
☐ SEP (type)________________

Sales initiative:

☐ Retail/Mall Program ☐ Community Meeting ☐ Member Meeting
☐ Local B2B Outreach ☐ Local Event Outreach ☐ Other____________

For proper commission processing, please print clearly and include the correct Agent ID number. Agents must be licensed, appointed and certified to receive commission. Incomplete agent information will cause delays in commission.

10. For AARP® MedicareRx plans use only

Plan ID

Employer ID

Branch ID

TEAR HERE

A UnitedHealthcare® Medicare Solution

This information is available for free in other languages. Please call our customer service number at 1-888-867-5575, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-888-867-5575, TTY 711, de 8 a.m. – 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打 1-888-867-5575 聯絡我們的客戶服務部, 聽語障專線711, 每週 7 天, 當地時間上午 8 時至晚上 8 時.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This page intentionally left blank.