MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
____Village of Bloomingdale___SPONSORED GROUP PLAN

To enroll in Express Scripts Medicare® (PDP) please provide the following information:

Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr. Mrs. Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Gender: M F	Social Security Number:	Home Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):		
City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address: City: State: ZIP Code:

Emergency Contact: [Optional]

Phone Number: [Optional]_____ **Relationship to You** [Optional] _____

E-mail Address: [Optional]

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.

Name: _____

Medicare Number

__ __ __ __ - __ __ __ - __ __ __ __

OR Medicare Claim Number

__ __ __ - __ __ - __ __ __ __ - __ __

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Please read and answer these important 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 <Plan Name>? 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:

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP), is offered by Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). (When this document says "we," "us" or "our," it means Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). When it says "plan" or "our plan," it means Express Scripts Medicare.) This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

Enrollment Requirements

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

IMPORTANT: Read and Sign Below:

- **Release of Information:** By joining this Medicare Advantage Prescription Drug Plan/Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <Plan Name> 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- (Medicare Advantage only) I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services authorized by <Plan Name> and contained in my <Plan Name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor <Plan Name > will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Address:
Phone Number:	Relationship to Enrollee:

[*Optional field:* **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**]

[*Optional field:* **Paying Your Plan Premiums:**
*MA-only, MA-PD plans and Part D plans with premiums insert***: You can pay your monthly plan premium** [*MA-PD plans with premiums insert:* **(including any late enrollment penalty that you currently have or may owe)] by mail <***insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.]**

[*MA-PD and PDPs with premiums insert:* **If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 benefit check or be billed directly by Medicare or RRB. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**