MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

Individual Change Form

Dear Member:

Complete this form only if you wish to change your MedicareBlue Rx (PDP) plan option. For premium or other changes, please call Customer Service (see phone numbers below).

To change to a different Medicare Prescription Drug Plan option with MedicareBlue Rx, fill out this form by checking the plan option you want and signing the form. Then mail the completed form back to us.

You may change your plan option during the annual enrollment period, from October 15 to December 7. Generally, you may not make changes at other times unless you meet certain special exceptions (see the Enrollment Period Determination section). For more information about enrollment periods please call Customer Service.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you select another plan option and we receive your completed form by the end of any month, your new benefit plan will generally begin the first of the following month. Selections made during the annual enrollment period (October 15-December 7) are effective January 1.

If you have any questions, please call MedicareBlue Rx Customer Service at **1-888-832-0075**, 8 a.m. to 8 p.m., daily, Central and Mountain Times. TTY hearing impaired users call **711**.

Thank you.

MEDICAREBLUE RX
INDIVIDUAL CHANGE FORM

Please mail this form to:
MedicareBlue Rx
P.O. Box 3178
Scranton, PA 18505

A. MEMBER INFORMATION (please print clearly):

Last Name:	First Name:	Middle Initial:

Member Number (Printed on your MedicareBlue Rx ID card):	Medicare Claim Number (Printed on your red, white and blue Medicare ID card):

Home Phone Number: ( ) –	Alternate Phone Number (optional): ( ) –	E-mail Address (optional):

Permanent Residence Street Address **(P.O. Box is not allowed)**:

City:	State:	ZIP Code:

B. PLAN OPTIONS (for premium information, see your Summary of Benefits):

Please check the box below for the plan option you wish to change to:
MedicareBlue Rx: ❑ Standard ❑ Premier

C. ENROLLMENT PERIOD DETERMINATION:

Typically, you may only enroll or change plan options in a Medicare Prescription Drug Plan during the annual enrollment period between October 15 and December 7. Additionally, there are exceptions that may allow you to change your plan option in a Medicare Prescription Drug Plan outside of the annual enrollment period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled. Your effective date will generally be the first of the month after your form is received by the plan.

❑ I am enrolling during the annual enrollment period, October 15 to December 7, for **an effective date on the following January 1.** (Note: The enrollment application must be received by December 7 for the enrollment to be effective on the following January 1.)

❑ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.

❑ I get extra help paying for Medicare prescription drug coverage as of (mm/dd/yyyy) _____/_____/_____.

❑ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I received notice of loss of extra help on (mm/dd/yyyy) _____/_____/_____.

❑ I am moving into or live in a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved or will move into the facility on (mm/dd/yyyy) _____/_____/_____.

❑ I am moving out of a Long-Term Care Facility (for example, a nursing home or long-term care facility) on (mm/dd/yyyy) _____/_____/_____.

❑ I belong to Big Sky Rx (a state pharmaceutical assistance program) provided by the state of Montana.

Enrollee name: _____

❑ Other Special Enrollment Period not identified above _____
If none of the statements apply to you or if you are not sure, please contact MedicareBlue Rx Customer Service (the phone numbers are on the front of this form) to see if you are eligible to enroll.

If you have special needs, alternative formats are available. Please contact MedicareBlue Rx Customer Service at the phone numbers on the front of this form.

D. PAYING YOUR PLAN PREMIUM:

You can continue your current premium payment method for next year or change it. Please select a premium payment option:

❑ Keep my current premium payment option

❑ Receive a paper bill. **Do not send a premium payment with this application.**

❑ Social Security deduction

❑ Railroad Retirement Board deduction

You can choose to pay your monthly plan premium, including any late enrollment penalty, each month by mail or by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check. You may also choose automatic deduction from your Social Security or RRB checks after you are enrolled. If Social Security/RRB does not approve your automatic deduction request, we will send you paper bills for your monthly premiums and resubmit your request. Once approved, it can take two or more months for the deduction to begin. During this time, you will receive paper bills and be responsible for paying your premium directly to the plan until the deduction begins. If you do not pay your premium for the months before the deduction takes effect, you may be disenrolled from the plan. Neither Social Security nor RRB allow retroactive withholding requests.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), the Social Security Administration will notify you. 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 RRB check or be billed directly by Medicare. Do NOT pay MedicareBlue Rx the Part D-IRMAA.

You can also choose to pay by Electronic Funds Transfer (EFT). You must sign and date the form, and send it along with a voided check to the plan. Contact Customer Service for a form at the phone number on the front of this form. It may take up to two months to process your request. Please pay your premiums billed to you on paper until your EFT is active. Any unpaid premiums due when EFT takes effect will be deducted at that time to bring your account up-to-date.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. 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, 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, 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. If you don't select a payment option, you will receive a bill each month.

Enrollee name: _____

E. SIGNATURE:

I want to transfer from my current plan option to the plan option I have selected here. 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 change form, including the information in Section F. 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. The information on this change 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.

Your Signature: _____ **Today's Date:** _____

❑ I give permission to the licensed agent identified below to enter my change form online through **www.YourMedicareSolutions.com**.

For Authorized Representative Use Only

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

Name (Print): _____ Phone number: (_____)_____

Address: _____

City: _____ State: _____ ZIP Code: _____

Relationship to Enrollee: _____

❑ I want all mail for this member sent to me.

For Agent Use Only

Agent Name (Print): _____

Agent #: _____ Agency #: _____

❑ Check if you have received this **completed** enrollment form with the enrollee's signature from the enrollee. This paper form must be submitted using one of the methods below within **two (2) calendar days** of the date you receive it. Sign and date below when you receive the form from the beneficiary.

Agent signature: _____

Date form received: _____ Phone number: (_____) _____

Check selected submission method and enter information as appropriate:

❑ Paper to online application. Enter online confirmation number:

_____

❑ Application faxed. Enter date faxed (keep fax confirmation sheet):

_____

❑ Application sent overnight. Be sure to keep the overnight receipt.

F. ENROLLMENT AUTHORIZATION: By completing this enrollment application, I agree to the following:

After carefully reading all statements in this section, please sign Section E of this form. Keep the copy marked "Enrollee" for your records.

1. I understand that MedicareBlue Rx (PDP) is a regional Medicare prescription drug plan and has a contract with the Federal government. Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota* and Blue Cross Blue Shield of Wyoming.*
   *Independent licensees of the Blue Cross and Blue Shield Association
2. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and Blue Shield plans offering MedicareBlue Rx, he/she may be paid based on my enrollment in MedicareBlue Rx.
3. **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that MedicareBlue Rx will release my information to Medicare and other plans as necessary for treatment, payment and health care operations, and as otherwise permitted by law. I also acknowledge that MedicareBlue Rx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.
4. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
5. I understand that beginning on the date MedicareBlue Rx coverage begins, I must get all of my prescription drug services from MedicareBlue Rx. Prescription drugs authorized by MedicareBlue Rx and contained in my MedicareBlue Rx Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICAREBLUE RX WILL PAY FOR THE SERVICES.**

Distribution: White Copy: Carrier Yellow Copy: Enrollee

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For More Information...

Contact your licensed and certified independent agent

Or call MedicareBlue Rx **1-888-832-0075**
TTY hearing impaired users call **711**
8 a.m. to 8 p.m., daily, Central and Mountain Times

Or visit us on the Web at
www.YourMedicareSolutions.com

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