STANDARD ENROLLMENT FORM FOR A MEDICARE-APPROVED DRUG DISCOUNT CARD AND A CREDIT TO HELP PAY FOR YOUR PRESCRIPTION DRUGS

Drug Card Sponsor Name	Drug Card Product Name

Enrollment Fee	Drug Card Sponsor Address

STEP 1: PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you have Medicare Part A or Medicare Part B? ❑ Yes ❑ No

If you answered "YES," please continue below. If you answered "NO," you are not eligible for this program.

Do you have outpatient prescription drug benefits under your State Medicaid Program? ❑ Yes ❑ No

If you answered "NO," please continue below. If you answered "YES," you are not eligible for this program.

STEP 2: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF

First Name Middle Initial Last Name	Date of Birth *(month/day/year)*	Sex

Residence Address: Street	City	State	ZIP Code

Social Security Number	Medicare ID Number *(from your red, white & blue Medicare card)*	Telephone Number *(with area code)*

STEP 3: PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you have TRICARE *(military health insurance)*? ❑ Yes ❑ No

Do you have Federal employee or retiree health insurance *(FEHB)*? ❑ Yes ❑ No

Do you have other health coverage that includes outpatient prescription drugs, such as employer or retiree plans? ❑ Yes ❑ No

NOTE: If your health coverage is through a Medicare Advantage plan, a Medigap policy (Medicare supplement insurance) or the Veteran's Administration (VA), answer "NO" to this question.

If you answered "YES" to any of the statements above, you may not be eligible for the credit. Please see the information on page 2 of the instructions, or call the Medicare-approved drug discount card sponsor you have selected for assistance.

If you answered "NO" to all of these questions, please continue to the next page.

Step 4: Please answer the following questions about your income

Does your State help you pay your Medicare Part A or Part B premiums? ❑ Yes ❑ No

Please check one: ❑ Single ❑ Married

If married, please include your spouse's Social Security Number:_____

Have you recently *(within the last 2 years)* retired or been widowed or divorced? ❑ Yes ❑ No

What is your current monthly income*? If you are married, include both your and your spouse's income.

My current monthly income (including my spouse's, if married) is: $_____

*(*Income includes money that you receive through retirement benefits from Social Security, Railroad, the Federal or State governments, or other sources, and benefits you receive for a disability or as a Veteran, plus any other sources of the type that you would report for tax purposes.)*

Step 5: Read all the information and sign your form

Release of Information: By applying for enrollment in this company's Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company that sponsors the drug discount card. The information will say whether I have Medicare (Hospital Insurance Part A and/or Medical Insurance Part B). I also allow the State Medicaid Program, Social Security Administration, and Internal Revenue Service, or any other agency with relevant information about me to give CMS or CMS' agents the information needed to determine if I am eligible for the Medicare-approved drug discount card and, if applying, for a credit toward prescription drugs.

Review of Eligibility: I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I also understand that by signing this application I am agreeing to a full investigation or review of my eligibility by States, Federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, you certify that you have read and understand the information on this entire enrollment form. If you can't sign, a representative may sign for you.

Federal law provides for fine or imprisonment, or both for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature_____Date _____

Your enrollment form is not complete unless it is signed.

You must return this completed enrollment form to the Medicare-approved drug discount card sponsor you have selected. Do not return your form to CMS. If you don't send this completed form to the sponsor you have chosen, your enrollment will be delayed.