National Rural Electric Cooperative Association
A Touchstone Energy® Cooperative

NRECA Medicare Part D
PRESCRIPTION DRUG PLANS
an Employer PDP

MedicareRx
Prescription Drug Coverage

Medicare Part D Enrollment Form

(See back of this form for Instructions)

EMPLOYER INFORMATION

Subgroup ID	Employer Name

TYPE OF ENROLLMENT

Election Type ☐ Initial Enrollment ☐ Open Enrollment ☐ Special Enrollment

If you choose Special Enrollment, which best describes you?

☐ Retiring - over age 65 Retirement Date: _____

☐ Eligible for low-income subsidy

☐ Losing creditable coverage Date of Loss of Creditable Coverage: _____

☐ Entering or leaving a health care institution (such as a nursing home) Date of Move: _____

☐ Other: Please Specify: _____

APPLICANT INFORMATION

Member ID #	First Name	Middle Initial	Last Name

Date of Birth	Gender (Please check one)	Marital Status (Please check one)
	☐ Female ☐ Male	☐ Divorced ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

Medicare Claim Number (Can be found on your Medicare Card. See sample on back of this form.)

Which one of these best describes you? (Please check one)

☐ Retired Employee ☐ Retired Attorney
☐ Retired Department Head ☐ Medicare Eligible Spouse
☐ Retired Manager ☐ Medicare Eligible Child
☐ Retired Director ☐ Medicare Eligible Director

☐ Disabled Employee ☐ Disabled Attorney
☐ Disabled Department Head ☐ Disabled Medicare Eligible Spouse
☐ Disabled Manager
☐ Disabled Director

For Disabled Applicants Only Date of Eligibility for Medicare: Month Day Year

Preferred Language/Format (Please check one) ☐ English ☐ Spanish ☐ Other Language/Format

Administrator: If the applicant was an employee, please complete the following fields:

Hire Date: Month Day Year

Termination Date: Month Day Year

If Medicare Eligible Spouse, Disabled Medicare Eligible Spouse or Medicare Eligible Child is chosen above, please complete the following fields.

Employee Member ID #	Employee First Name	Employee MI	Employee Last Name

Employee Date of Birth	Employee Gender (Please check one)
	☐ Female ☐ Male

Administrator: Please complete the following fields:

Employee Date of Hire	Employee Date of Termination	Employee Date of Disability

Permanent Residence Address (P.O. Box not allowed)	City	State	Zip Code

Mailing Address (if different)	City	State	Zip Code	Phone Number

Are you a resident of a long-term facility such as a nursing home? ☐ Yes ☐ No
If yes, please provide the following information:

Facility Name

Address	City	State	Zip Code

PLAN INFORMATION

Select a Plan (Please check one)

☐ Basic ☐ Basic Plus ☐ Copayment ☐ Enhanced ☐ Enhanced Plus

Secondary Insurance ID Number (Rx)	Secondary Insurance Group Number

AUTHORIZATION SIGNATURES

By signing below, I acknowledge that I understand the Release of Information on the back of this form.

Applicant or Authorized Representative Signature | Today's Date

If you are the authorized representative signing this form, please provide the following information.

Name	Relationship to Applicant

Address	City	State	Zip Code	Phone Number

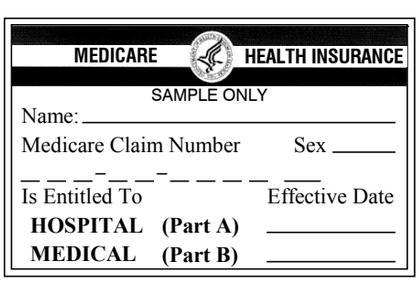
Instructions

For the applicant: If you are concerned about a field, follow the instructions below. You do not need to complete shaded areas of the enrollment form.

For the administrator: Complete all shaded areas as appropriate.

EMPLOYER INFORMATION	**Provide information about the co-op or system.**
Subgroup ID	Administrator completes.
Employer Name	Write the name of the system with which you are associated.
TYPE OF ENROLLMENT	**Provide information about the timing of your enrollment in Medicare Part D.**
Election Type	Check Initial Enrollment if you are applying in the 7-month period when you first become eligible for Medicare. Check Open Enrollment if you are enrolling in or changing plans during an open enrollment period (November 15 - December 31). Check Special Enrollment if you are enrolling in or changing plans and your circumstances match any of the reasons listed on the other side of this form. If you do not see your reason listed there, choose other and describe your reason. If you have questions, call the Member Contact Center at 1-866-673-2299.
APPLICANT INFORMATION	**Provide information specific to the person applying for coverage.**
Member ID #	NRECA needs this number to verify that you are in their records.
First Name	Write your first name as it appears on your Medicare ID card.
Last Name	Write your last name as it appears on your Medicare ID card.
Medicare Claim Number	This number appears on your Medicare card. Fill it in exactly as it appears on your card. (See sample card below.)
Date of Eligibility for Medicare	If you are disabled and applying for Medicare Part D, fill in the date you became eligible for Medicare. This date usually differs from your date of disability.
Preferred Language	Check the language in which you prefer to receive written communication.
Permanent Residence Address	Write the address that you consider your permanent residence, not a second home or vacation home. A P.O. Box is not allowed by Medicare.
Mailing Address	If you receive the majority of your mail at an address other than your permanent residence, write the address here. You may use a P.O. Box.
Are you a resident of a long-term care facility such as a nursing home?	Check yes or no. If yes, fill in the long-term care facility information. If no, go to Plan Information.
PLAN INFORMATION	**Provide information about the plan you want to join and other coverage you may have.**
Select a Plan	Check the NRECA Part D Plan in which you want to enroll. See brochure for descriptions of the plans.
Secondary Insurance ID Number (Rx)	If you are covered under more than one prescription drug plan (such as a spouse's coverage or Tricare), fill in your ID number for that coverage. (NRECA is not considered secondary coverage.)
Secondary Insurance Group Number (Rx)	If you are covered under more than one prescription drug plan (such as a spouse's coverage or Tricare), fill in the group number for that coverage. (NRECA is not considered secondary coverage.)

Sample


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

__ __ __–__ __–__ __ __ __ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Release of Information

NRECA is a Medicare-approved Part D Plan sponsor and has a contract with the Federal government. By joining the NRECA Medicare Part D Prescription Drug Plan, an Employer PDP, I agree that 1) I can be in only one Medicare prescription drug plan at a time, 2) my coverage in another Medicare prescription drug plan, if any, will end with my enrollment in this Plan, and 3) Part D coverage is in addition to my Medicare Part A or Part B coverage, which must also remain current. I must tell the Plan of other drug coverage now or in the future. I may leave this Plan only during Open Enrollment, or under certain special circumstances, by contacting the Plan or 1-800-MEDICARE (TTY: 1-877-486-2048). If I leave this Plan and do not have or get other Medicare prescription drug coverage or other creditable prescription drug coverage (at least as good as Medicare's standard plan), I may have to pay a late enrollment penalty, imposed by Medicare, in addition to my Medicare Part D premium in the future, and I may lose my NRECA medical coverage, if any. I will read the Summary Plan Description and Evidence of Coverage and abide by the rules, such as the right to appeal plan decisions about payment or services. I acknowledge that my information may be released to Medicare and others as necessary for treatment, payment or health care operations, and Medicare may release it for research and other purposes as allowed by applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that 1) if I intentionally provide false information, I will be disenrolled from the Plan, 2) my signature (or the signature of my authorized representative) on this form means that I have read and understand the contents of this application. If signed by an authorized representative, this signature certifies that: 1) this person is authorized to act on my behalf under State law where I live to complete this enrollment and 2) documentation of this authority is available upon request by the Plan or by Medicare.