

Community CCRSM PDP

Local Pharmacists Caring for You.

Medicare Prescription Drug Plan 2012 Enrollment Form

Instructions for completing the enclosed 2012 Community CCRSM PDP Enrollment Form:

1. Each applicant may submit only one Enrollment Form.
2. You will need your Medicare card to fill in the requested information.
3. Write clearly, answer each question accurately and review your answers.
4. Mail your signed and dated Enrollment Form in the enclosed postage-paid envelope. If you do not use the postage paid envelope, include the proper postage and mail to:

Community CCRx
PO Box 52442
Phoenix, AZ 85072-2442

Note: we offer two other enrollment options, including:



Enroll and Submit by Phone:

A Plan Representative can take your information by phone and submit your Enrollment Form. Call toll free, 1-866-423-5040, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-866-684-5351), 7 days a week.



Enroll and Submit Online:

You have the option to enroll through our secure website at www.CommunityCCRx.com.



If you are an agent: Please proceed with submission in accordance with CVS Caremark agent requirements.

Community CCRx PDP is offered by SilverScript® Life Insurance Company in New York and Pennsylvania Life Insurance Company in all other states, the District of Columbia and the U.S. Virgin Islands.

Y0080_ENR_CCRXApp_0811 CMS Approved 08/25/2011 1 PLEASE RETURN TO COMPANY CCRx-ENRAPP-AGCO-12Kit

2012 Community CCRxSM PDP

Medicare Prescription Drug Plan Individual Enrollment Form

Where did you get this form? Online Event Agent Retail Pharmacy Requested by phone

Section 1: To Enroll in Community CCRx PDP Please Provide the Following Information

Please check which plan you want to enroll in.

Community CCRx Basic (PDP)

Community CCRx Choice (PDP)

Section 2: Please Complete the Information Below Exactly as it Appears on Your Medicare Card

MEDICARE HEALTH INSURANCE	
SAMPLE ONLY	
Last Name	Suffix
First Name	MI
Medicare Claim Number	
Is Entitled to Hospital Insurance (Part A)	Effective Date
Medical Insurance (Part B)	

Use 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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

Please Provide the Following Information

Birth Date MM / DD / YYYY	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Primary Phone Number () -	Cell Phone Number () -
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Permanent Residence/Long-term Care Facility Address (PO Box is not allowed)

Street Number	Street Name
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Permanent Residence/Long-term Care Facility Street Address Line 2 (Apt/Suite/Unit)	County
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City	State	ZIP Code
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Long-term Care Facility Telephone (if applicable) () -

Mailing Address (if different from above address) Same as permanent address

Mailing Street Address Line 1 Street Number Street Name
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Mailing Street Address Line 2 (Apt/Suite/Unit)	County
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City	State	ZIP Code
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E-mail Address

By providing your email address, you agree to receive electronic correspondence from the plan.

Section 4: Please Read and Answer These Important Questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

Do you have other prescription drug coverage in addition to Community CCRx? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of Coverage _____

ID# for This Coverage _____

Group# for This Coverage _____

2. Would you like to receive this information in Spanish? Yes No

¿Le gustaría recibir esta información en español? Yes No

If you need information in another format or language, please contact Community CCRx at 1-866-423-5040, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-866-684-5351), 7 days a week.



Section 5: 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 Community CCRx, 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 an employer or union, joining Community CCRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Community CCRx. 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.

Section 6 : Please Read Terms and Sign on Page 9

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

Community CCRx is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Community CCRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Community CCRx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7 of next year), unless I qualify for certain special circumstances.

Community CCRx serves a specific service area. If I move out of the area that Community CCRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Community CCRx network pharmacies. Once I am a member of Community CCRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Community CCRx when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Community CCRx, he or she may be paid based on my enrollment in Community CCRx.

Counseling services may be available in my 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.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that Community CCRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Community CCRx 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 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.

Section 6 (continued) : Please Read Terms and Sign on Page 9

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period between October 15 and December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment Period. Please read the below 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 that reason which will help us to determine your enrollment period.

Reasons for Annual Enrollment Period Eligibility

I am enrolling between 10/15/11–12/7/11 the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

I am new to Medicare.

I have previously had Medicare but am now turning 65.

I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on / / .

Reasons for Special Enrollment Period Eligibility

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

I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on / / .

I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on / / .

I get Extra Help paying for Medicare prescription drug coverage but do not have Medicaid.

In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan with prescription drug coverage for the first time.

In the last 12 months, I turned 65 and joined a Medicare Advantage Plan with prescription drug coverage.

I am (circle one) leaving/losing/joining employer or union coverage on / / .

I belong to a Pharmacy Assistance Program provided by my state.

I received a notice from the Plan/Medicare that I am eligible for a Special Enrollment Period (SEP).

I recently moved outside the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on / / .

I am disenrolling from a Medicare cost plan that I had prescription drug coverage from.

I am being disenrolled from a Medicare Special Needs Plan because I no longer have special needs status.

I recently lost Medicare Part B but I still have Part A.

I am losing or lost my participation in a Pharmacy Assistance Program provided by my state on / / .

My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

I recently left a PACE program (Program of all inclusive care for the elderly.)

I live in, am moving into, or recently moved out of a Long-term Care Facility. I (circle one) moved/will move into/out of this facility on / / .

I am disenrolling from my Medicare Advantage Plan between 1/1/2012 and 2/14/2012 to enroll in original Medicare.

Other

None of these statements apply to me. Please contact Community CCRx at 1-866-423-5040, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-866-684-5351), 7 days a week.

Applicant's Signature

Your Signature

Today's Date

____/____/____

Print Name (please print)

Section 7: Power of Attorney/Authorized Representative

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use)

Name

Address

City

State

ZIP Code

Phone Number

____-____-____

Relationship to Enrollee

Child

Friend

Spouse

Other

Signature

Today's Date

____/____/____

Please check if authorized representative should receive duplicate copy of plan materials.

Agent/Plan Use Only

Application Received Date

____/____/____

Requested Coverage Effective Date

____/____/____

Agent ID #

Agent Name (please print)

Agent Signature

Checklist to Remember:

Enter Application in the portal? Y

Portal Confirmation #SS _____

Submit copy to Community CCRx
w/in 48 hrs.? Y

Scope of appointment attached? Y
(Not required for apps mailed to agent)

After entering the application into the portal, please send all pages of the signed, completed Enrollment Application AND the signed, completed Scope of Appointment Form to:

Community CCRx
PO Box 52442
Phoenix, AZ 85072-2442
or fax to: 1-866-635-3177

Agent Use Only — Please Complete

How did you meet this applicant?

Personal Marketing Appointment

Sales event/Seminar

Retail

Other _____

Internal Office Use Only

Initial Receipt Date

____/____/____

PBP #

Priority Code

____-____-____

Community CCRxSM PDP is a federally qualified Medicare contracting Prescription Drug Plan.