

Enrollment Eligibility

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between October 15 and December 07 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

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| <p><input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.</p> <p><input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on __ __/__ __/__ __ __ __.</p> <p><input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on __ __/__ __/__ __ __ __.</p> <p><input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage but do not have Medicaid.</p> <p><input type="checkbox"/> In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan with prescription drug coverage for the first time.</p> <p><input type="checkbox"/> In the last 12 months, I turned 65 and joined a Medicare Advantage Plan with prescription drug coverage.</p> <p><input type="checkbox"/> I am (circle one) leaving/losing/joining employer or union coverage on __ __/__ __/__ __ __ __.</p> <p><input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.</p> <p><input type="checkbox"/> I received a notice from the Plan/Medicare that I am eligible for a special enrollment period (SEP).</p> | <p><input type="checkbox"/> 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 __ __/__ __/__ __ __ __.</p> <p><input type="checkbox"/> I am disenrolling from a Medicare cost plan that I had prescription drug coverage from.</p> <p><input type="checkbox"/> I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.</p> <p><input type="checkbox"/> I recently lost Medicare Part B but I still have Part A.</p> <p><input type="checkbox"/> I am losing or lost my participation in a pharmacy assistance program provided by my state on __ __/__ __/__ __ __ __.</p> <p><input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.</p> <p><input type="checkbox"/> I recently left a PACE program (Program of all inclusive care for the elderly.)</p> <p><input type="checkbox"/> 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 __ __/__ __/__ __ __ __.</p> <p><input type="checkbox"/> I am disenrolling from my Medicare Advantage Plan between 1/1/2012 and 2/14/2012 to enroll in original Medicare.</p> |
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- None of these statements apply to me. Please contact us at 1-866-552-6106 to see if you are eligible to enroll. We are open from 8 a.m. to 2 a.m., ET, 7 days a week. TTY users call 1-866-552-6288.

Paying Your Plan Premium

You can pay your Medicare Prescription Drug Plan monthly premium (including any late enrollment penalty you may owe) by mail, automatic bank draft withdrawal, automatic deduction from your monthly Railroad Retirement Board check, automatic deduction from your Social Security benefit check, or credit card. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. 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 Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to SilverScript Insurance Company. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and co-insurance. Additionally, 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 about this Extra Help, 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 with your Medicare prescription drug coverage costs, 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 does not cover, please select an option below to pay the remaining premium that Medicare does not cover.

Please select a premium payment option. (If you don't select an option, you will receive a monthly bill.)

Automatic deduction from your Social Security or Railroad Retirement Board benefit check

Automatic deduction from your Social Security/Railroad Retirement Board benefit check may take two or more months to begin and you are responsible for paying your monthly premiums from your enrollment effective date till the date your automatic deduction from SSA begins. If your automatic deduction is not approved we will send you a monthly bill.

Electronic funds transfer (EFT) from your bank or automatic deduction from your credit card. By selecting EFT, I authorize the bank or financial institution named below to withdraw a deduction of up to \$200 at a time from the indicated account as payment of premiums payable to SilverScript Insurance Company. The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received.

Deduct from **Checking** **Savings**

Deduct from Credit Card

Name on Acct. _____

Name on Card _____

Financial Institution _____

Type of Card (VISA/MC) _____

Routing/Acct. # _____

Card # _____

(Both 1st and 2nd set of numbers at bottom left of check)

(Record entire card number)

Acct. Holder Signature _____

Card Holder Signature _____

Receive monthly bills that you can pay by mail. Reminder, if you have secondary coverage that pays for part of your premiums (for example: from your employer or an SPAP) then you must choose monthly bills that you can pay by mail in order for the secondary coverage to be applied correctly.

Alternate Languages and/or Formats

Would you like to receive this information in Spanish? ¿Le gustaría recibir esta información en español? Y N

To receive information in an alternate format, such as Braille, audio tape or large print, please contact us at:

1-866-235-5660, 24 hours a day, 7 days a week. TTY: 1-866-236-1069.



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 SilverScript Insurance Company, 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 SilverScript Insurance Company could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SilverScript Insurance Company. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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.

Please Read Terms and Sign Below

By completing this enrollment application, I agree to the following: SilverScript Insurance Company offers two Medicare drug plans 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 SilverScript Insurance Company 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 SilverScript Insurance Company 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), unless I qualify for certain special circumstances.

SilverScript Insurance Company serves a specific service area. If I move out of the area that SilverScript Insurance Company 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 SilverScript Insurance Company network pharmacies. Once I am a member of SilverScript Insurance Company, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from SilverScript Insurance Company 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 SilverScript Insurance Company, he/she may be paid based on my enrollment in SilverScript Insurance Company. 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 SilverScript Insurance Company will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that SilverScript Insurance Company 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. 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.

Please sign below to certify you have read, understand, and agree to the conditions written above.

<p>_____</p> <p>Signature _____ Today's Date _____</p> <p>Authorized representatives must sign above and complete the box below.</p> <p>Name _____</p> <p>Address _____</p> <p>_____</p> <p>Telephone _____</p> <p>Relationship to Enrollee _____</p> <p>Email _____</p> <p><input type="checkbox"/> Please check if Authorized representative should receive duplicate copy of Plan materials.</p>	<p align="center">Agent/Plan Use Only</p> <p>Application Recd _____/_____/_____</p> <p>Effective Date _____/_____/_____</p> <p>CUID _____ Agent ID _____</p> <p>Agent Name _____</p> <p>Agent Signature _____</p> <p>Portal Confirmation #SS _____</p> <p align="center">Checklist to remember</p> <p><input type="checkbox"/> Enter application in the portal</p> <p><input type="checkbox"/> Submit copy to SS w/in 48 hrs.</p> <p><input type="checkbox"/> Submit Scope of appt (Not req for apps to agent)</p> <p>After entering the application into the portal, please send all pages of the signed, completed Application AND Scope of Appointment Form to:</p> <p>SilverScript Insurance Company Attn. Agent Processing, PO Box 52134, Phoenix AZ 85072 fax: 1-866-552-6205 email: EnrollmentVerification@Caremark.com</p>
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