

## Medicare Part D Enrollment Form

(See back of this form for Instructions)

### EMPLOYER INFORMATION

Subgroup ID	Employer Name
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### TYPE OF ENROLLMENT

Election Type     Initial Enrollment     Open Enrollment     Special Enrollment

If you choose Special Enrollment, which best describes you?

- |  |   |
|--|---|
| <input type="checkbox"/> Retiring - over age 65    Retirement Date: _____                            | <input type="checkbox"/> Entering or leaving a health care institution<br>(such as a nursing home)    Date of Move: _____ |
| <input type="checkbox"/> Eligible for low-income subsidy   | <input type="checkbox"/> Other: Please Specify: _____   |
| <input type="checkbox"/> Losing creditable coverage    Date of Loss of<br>Creditable Coverage: _____ |   |

### APPLICANT INFORMATION

Social Security #	First Name	Middle Initial	Last Name
Date of Birth	Gender (Please check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status (Please check one) <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> 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)	<input type="checkbox"/> Disabled Employee <input type="checkbox"/> Disabled Attorney
<input type="checkbox"/> Retired Employee <input type="checkbox"/> Retired Attorney	<input type="checkbox"/> Disabled Department Head <input type="checkbox"/> Disabled Medicare Eligible Spouse
<input type="checkbox"/> Retired Department Head <input type="checkbox"/> Medicare Eligible Spouse	<input type="checkbox"/> Disabled Manager <input type="checkbox"/> Disabled Director
<input type="checkbox"/> Retired Manager <input type="checkbox"/> Medicare Eligible Child	<b>For Disabled Applicants Only</b> Month    Day    Year
<input type="checkbox"/> Retired Director <input type="checkbox"/> Medicare Eligible Director	<b>Date of Eligibility for Medicare:</b> _____

Preferred Language (Please check one)	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other
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 Social Security Number	Employee First Name	Employee MI	Employee Last Name
Employee Date of Birth	Employee Gender (Please check one) <input type="checkbox"/> Female <input type="checkbox"/> Male		
Administrator: Please complete the following fields:			
Employee Date of Hire	Employee Date of Termination	Employee Date of Disability	

Permanent Residence Address	City	State	Zip Code	Phone Number
Mailing Address (if different from permanent address)	City	State	Zip Code	

Are you a resident of a long-term facility such as a nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> 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
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### 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
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**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.

<b>EMPLOYER INFORMATION</b>	<b>Provide information about the co-op or system.</b>
Subgroup ID	Administrator completes.
Employer Name	Write the name of the system with which you are associated.
<b>TYPE OF ENROLLMENT</b>	<b>Provide information about the timing of your enrollment in Medicare Part D.</b>
Election Type	<p>Check Initial Enrollment if you are applying in the 7-month period when you first become eligible for Medicare.</p> <p>Check Open Enrollment if you are enrolling in or changing plans during an open enrollment period (November 15 - December 31).</p> <p>Check Special Enrollment if you are enrolling in or changing plans and your circumstances match any of the following (other reasons may apply):</p> <ul style="list-style-type: none"> <li>• Retiring - over age 65</li> <li>• Eligible for low-income subsidy</li> <li>• Losing creditable coverage</li> <li>• Entering or leaving a health care institution (such as a nursing home)</li> <li>• If you do not see your reason listed here, choose other and describe your reason. If you have questions, call the Member Contact Center at 866.673.2299.</li> </ul>
<b>APPLICANT INFORMATION</b>	<b>Provide information specific to the person applying for coverage.</b>
Social Security Number	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. Do not use a P.O. Box.
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.
<b>PLAN INFORMATION</b>	<b>Provide information about the plan you want to join and other coverage you may have.</b>
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.)

### Release of Information

By joining NRECA's Medicare Part D Plan, 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 health 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 800.Medicare (TTY: 877.486.2048). If I leave this Plan and do not get other Medicare prescription drug coverage or other creditable coverage\*, 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 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 your behalf under State law where you reside to complete this enrollment and 2) documentation of this authority is available upon request by the Plan or by Medicare.

### Sample

<b>MEDICARE</b>		<b>HEALTH INSURANCE</b>
SAMPLE ONLY		
Name: _____		
Medicare Claim Number	Sex	_____
_____	_____	_____
Is Entitled To	Effective Date	_____
<b>HOSPITAL (Part A)</b>	_____	_____
<b>MEDICAL (Part B)</b>	_____	_____

\*Creditable coverage means prescription drug coverage that is at least as good as Medicare Part D (e.g., VA, TRICARE, a spouse's employer plan).