

## ENROLLMENT APPLICATION



### INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

Please contact BlueRx PDP at 1-866-682-7975 (TTY users should call 711) to inquire about materials on audio CD or for telephone translation services. Our office hours are 8:00 AM - 8:00 PM, Monday to Sunday.

### WAYS TO ENROLL



**Mail:** Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Highmark BlueRx  
P.O. Box 535042  
Pittsburgh, PA 15253-9923



**Phone:** Complete your application over the phone toll-free at **1-866-682-7975** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.



**Online:** Complete your application online at **[www.highmarkbcbs.com/medicare](http://www.highmarkbcbs.com/medicare)**



**In person:** Bring your application to a Medicare Solutions Seminar or other Highmark authorized locations. Call the toll-free number to find a meeting in your area.

**Pennsylvania and West Virginia**

## STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

BlueRx PDP 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 coverage Part A or Part B. It is my responsibility to inform BlueRx PDP 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 BlueRx PDP 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.

BlueRx PDP serves a specific area. If I move out of the area that BlueRx PDP 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 BlueRx

PDP network pharmacies. Once I am a member of BlueRx PDP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueRx PDP 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 BlueRx PDP, he/she may be paid based on my enrollment in BlueRx PDP. 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.

## PEOPLE WITH LIMITED INCOMES

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.

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 doesn't cover.

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](http://www.socialsecurity.gov/prescriptionhelp).

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## RELEASE OF INFORMATION

By joining this Medicare prescription drug plan, I acknowledge that BlueRx PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueRx PDP 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.

## PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment

and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Department.

## PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

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 BlueRx PDP the Part D-IRMAA.



Please specify the type of insurance  Active Employer Group Insurance  Retiree Coverage  
 Veteran's Administration Coverage  Direct Pay Policy  
 Federal Black Lung Coverage  Supplemental Coverage  
 Workman's Compensation Coverage

Is this insurance provided by  Your Employer  Your Spouse's Employer  Individual Plan  
 Does your employer have  1-19 employees  20-99 employees  more than 100 employees  
 Does your spouses' employer have  1-19 employees  20-99 employees  more than 100 employees

Your employer's name: \_\_\_\_\_ Your insurance name: \_\_\_\_\_  
 Your insurance policy #: \_\_\_\_\_ Your insurance group #: \_\_\_\_\_  
 Spouse's employer's name: \_\_\_\_\_ Spouse's insurance name: \_\_\_\_\_  
 Spouse's insurance policy #: \_\_\_\_\_ Spouse's insurance group #: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTION**

Are you a resident in a long-term care facility, such as a nursing home? ..... Yes  No   
 If "Yes", please provide the following information: Name of Institution: \_\_\_\_\_  
 Address & Phone Number of Institution (number and street): \_\_\_\_\_

**STOP - 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 BlueRx PDP, 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 BlueRx PDP could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join BlueRx PDP. 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 AND SIGN BELOW**

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 BlueRx PDP or by Medicare.

**Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

If you are the authorized representative, you must sign above and provide the following information:

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone Number:** ( ) \_\_\_\_\_ **Relationship to Enrollee:** \_\_\_\_\_

**PLEASE RETURN THE TOP COPY OF THIS FORM AND KEEP THE BOTTOM COPY FOR YOUR RECORDS.**



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**PENNSYLVANIA AND WEST VIRGINIA**