Community CCRx[SM] PDP

Local Pharmacists Caring for You.

Medicare Prescription Drug Plan

2012 Enrollment Form

Instructions for completing the enclosed 2012 Community CCRx[SM] 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.

2012 Community CCRx℠ 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 SAMPLE ONLY HEALTH INSURANCE

Last Name ______ Suffix ______

First Name ______ MI ______

Medicare Claim Number ______

Effective Date

Is Entitled to Hospital Insurance (Part A) ___/___/___

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 M M / D D / Y Y Y Y

Sex ❑ M ❑ F

Primary Phone Number ( ) –

Cell Phone Number ( ) –

Permanent Residence/Long-term Care Facility Address (PO Box is not allowed)

Street Number Street Name

Permanent Residence/Long-term Care Facility Street Address Line 2 (Apt/Suite/Unit)

County

City **State** **ZIP Code**

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

Mailing Street Address Line 2 (Apt/Suite/Unit)

County

City **State** **ZIP Code**

E-mail Address

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

Section 3: 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 Community CCRx.***

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

❑ **Monthly payments by personal check.** You will be mailed a premium invoice each month. ***Do not send payment with this enrollment form***.

❑ **Automatic Bank Draft Withdrawal.** Please send us a VOIDED check and fill in the requested information, which allows us to deduct your monthly payment from your bank account. *By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization named below to pay my premium through electronic bank withdrawal payable to SilverScript Insurance Company or Pennsylvania Life Insurance Company. I authorize the deduction of up to $200 at a time. The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received.*

Please choose one of the following: ❑ Checking ❑ Savings

Name on Account ____________________

Financial Institution ____________________

Routing Number ____________________

Account Number ____________________

Name
Address
Ci , State Zi
VOID
llars

Routing Number Account Number

Account Holder Signature ____________________

❑ **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 three 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.

❑ **Credit card:** The option to pay using a credit card will be included on your monthly invoice.

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 CCRx℠ PDP is a federally qualified Medicare contracting Prescription Drug Plan.