

PrescribaRxSM PDP

Medicare Prescription Drug Plans

2010 Enrollment Form

Follow these easy steps to enroll in a PrescribaRx Medicare Prescription Drug Plan.

Note: Each applicant should fill out a separate enrollment form.

1. Have your Medicare card ready. You will need to fill in the requested information EXACTLY as it appears on your Medicare card to avoid delays with your enrollment.
2. Read each section carefully to be sure that you understand the information. Print legibly and fill in each section completely.
3. Sign and date the enrollment form. (Your enrollment form is not complete until you sign and date it.)
4. If mailing in your application, use the enclosed envelope to send back the following:
 - Your signed application
 - Power of Attorney documentation, if applicable
 - A voided check, if applicable

Note: If you have enrolled with us before, you may not need to fill out this enrollment form. Call us at 1-800-818-0007, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-777-9083) every day, to find out how you should enroll.

How to Submit your Enrollment:

Please fax your completed enrollment form to: 1-866-635-3177.

Or mail the form in the enclosed envelope to:

Regular Mail:	Overnight (For Agent Use Only):
Universal American Part D Enrollment P.O. Box 1593 Pensacola, FL 32591	Universal American Part D Enrollment 411 N Baylen St Pensacola, FL 32501

You also have the option to enroll online instead at our Web site: www.Universal-American-Medicare.com.

Have any questions? Call us at 1-800-823-9990, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-777-9083) every day. We'll be glad to help.

Please do not submit the same application or apply to the same plan more than once to avoid delays with your enrollment.

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PRx-FORMBOOK 2010

2010 PrescribaRx PDP Medicare Prescription Drug Plans

Individual Enrollment Request Form (For New Members Only)

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

Section 1: To Enroll in PrescribaRx, Please Provide the Following Information You can find your plan premium in the enclosed Summary of Benefits

Please check which plan you want to enroll in:

- PrescribaRx Bronze PrescribaRx Gold
 \$ ____ . ____ per month \$ ____ . ____ per month

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) _____

Please take out your Medicare Card to complete this section. Please fill in these blanks so they match your red, white, and blue Medicare card. You must have Medicare Part A OR Part B to join a Medicare Prescription Drug plan, such as PrescribaRx. **An incorrect or incomplete Medicare claim number may cause a delay or denial of coverage.**

Birth Date: ____ / ____ / ____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Primary Phone Number: (____) _____ - _____
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Permanent Residence Street Address Line 1: (May not be a P.O. Box)

Street Number _____ Street Name _____

Permanent Residence Street Address Line 2: (Apt/Suite/Unit) _____	County: _____
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City: _____	State: _____	ZIP Code: _____
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Mailing Address: Same as permanent address

Mailing Street Address Line 1:

Street Number _____ Street Name or P.O. Box Number _____

Mailing Street Address Line 2: (Apt/Suite/Unit) _____	County: _____
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City: _____	State: _____	ZIP Code: _____
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E-mail Address: _____

Section 3: Paying Your Plan Premium

You can pay your Medicare prescription drug plan monthly premium by mail, by Automatic Bank Draft Withdrawal, or by automatic deduction from your Social Security benefit check.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for a portion of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance amounts. 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.

How would you like to pay your monthly Medicare prescription drug plan premium? Please check the appropriate box:

- Automatic Bank Draft Withdrawal. Please attach 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 American Progressive Life & Health Insurance Company of New York 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 _____ 2008
Address _____
City, State, Zip _____ Date _____
Pay to the order of _____ \$ _____ Dollars
Memo _____
⑆ 1 2 3 4 5 6 7 8 9 ⑆ ⑆ 1 2 3 4 5 6 7 8 9 ⑆ 2 0 0 8

Routing Number Account Number

Account Holder Signature _____

- Monthly payments by personal check. You will be mailed a premium statement each month.
Do not send payment with this enrollment form.
- Social Security benefit check deduction. Please note: Social Security Administration (SSA) deduction is completed through the SSA and may take three or more months to begin. (In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Section 4: Please Read and Answer These Important Questions

1. Other than Medicare, 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 PrescribaRx plan? 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. 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 of Institution (number and street):

City:

State:

Zip Code:

Phone Number:

3. Please check this box if you would prefer that we send you information in Spanish.
Please contact PrescribaRx at 1-800-823-9990, 8:00 a.m. to 8:00 p.m. in your local time zone
(TTY users call 1-800-777-9083) every day, if you need information in another format or language.



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 PrescribaRx, 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 PrescribaRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PrescribaRx. 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 and Sign on Page 5

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

PrescribaRx 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 PrescribaRx 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 PrescribaRx 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 (November 15 – December 31), unless I qualify for certain special circumstances.

PrescribaRx serves a specific service area. If I move out of the area that PrescribaRx 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 PrescribaRx network pharmacies. Once I am a member of PrescribaRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PrescribaRx 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 PrescribaRx, he or she may be paid based on my enrollment in PrescribaRx.

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.

Section 6 (continued): Please Read and Sign Below

Release of Information:

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

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between November 15 and December 31 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 following 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 an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Please indicate your enrollment period:

- Annual Election Period (If today's date is between 11/15/09-12/31/09)
- Initial Election Period-New to Medicare

If Special Election Period, please choose one:

- I recently moved outside of the service area for my current plan.
- I recently moved and this plan is a new option for me. I moved on ____/____/____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get Extra Help paying for Medicare prescription drug coverage.
- I no longer qualify for Extra Help paying for my Medicare prescription drug coverage.
I stopped receiving Extra Help on ____/____/____.
- I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home).
I moved or will move out of the facility on ____/____/____.
- I recently left a PACE program on ____/____/____.
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
I lost my coverage on ____/____/____.
- I am leaving employer or union coverage on ____/____/____.
- I belong to a pharmacy assistance program provided by my state.
- Eligible for coverage through the Department of Veteran Affairs.
- I recently returned to the United States after living permanently outside of the U.S.
- Other: _____*

* To see if you are eligible to enroll, please contact PrescribaRx at 1-800-823-9990, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-777-9083) every day.

Your Signature:

Today's Date:

____/____/____

Print Name: (please print)

Section 7: Power of Attorney/Authorized Representative

If you are the authorized representative, you must sign above in Section 6 and provide the following information. Power of Attorney (POA) or authorized representative documentation needs to be submitted with the application.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____

Relationship to Enrollee: Child Friend Spouse Other

Agent Use Only

Agent Name: *(please print)*

Today's Date: ____/____/____ Proposed Effective Date: ____/____/____

Agent ID Number: _____ Agent Signature: _____

POS: In-store pharmacy In-office at physician practice Pharmacy material lead
 Physician material lead Seminar Other _____

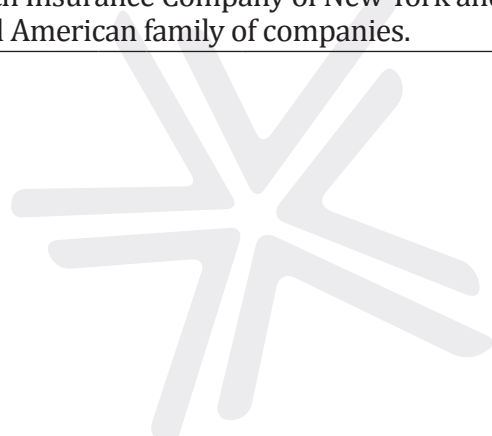
If you are submitting this application through the AgentLink process, remember to print and complete the cover sheet, indicating the subscriber ID. Fax or mail in the cover sheet along with a copy of this application **within 24 hours of receipt of Agentlink confirmation.**

Internal Use Only

APPLICATION RECEIPT TRACKING

Initial Receipt Date at Field Office:	Medicare Services Inventory Control Receipt:	Medicare Services Deemed Complete:
____/____/____	____/____/____	____/____/____
Group Code: _____	Cycle # _____	PBP # _____
Provider #: _____		

PrescribaRx™ PDP is a Medicare-approved Part D sponsor offered by the following organizations that contract with the Federal government: American Progressive Life & Health Insurance Company of New York and Pennsylvania Life Insurance Company, members of the Universal American family of companies.



PrescribaRxSM PDP

Thank you for considering PrescribaRxSM PDP. We look forward to serving your prescription drug needs with collaborative care and helpful member service.

Should you decide to enroll in our plan, within 10 calendar days of receipt of the enrollment request, you will receive new-member information from us about your plan, so watch for important mail from PrescribaRx.

Here's what you can also expect:

- 1. We will send you a *Member Acknowledgment Letter* telling you that we have received your request to enroll in PrescribaRx.**
- 2. We will also send your 2010 PrescribaRx Member ID Card to use when you visit your pharmacy and fill a prescription beginning January 1, 2010.**
- 3. We will call you to welcome you to PrescribaRx and confirm the plan you've selected. We'll also make sure your personal information is correct and answer any questions you may have.**
- 4. We will send you a Welcome Kit containing your welcome letter, a list of covered drugs (formulary) and an Evidence of Coverage document.**

Remember, if you have any questions, you can always call us for assistance at 1-800-818-0007 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-777-9083) every day.

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the Web, you may use the Web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-818-0007 to obtain a copy of the plan ratings for this plan. TTY users call 1-800-777-9083.

For more information about PrescribaRx, visit us at www.Universal-American-Medicare.com.

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Customer Service Center

Prospective Members Call:
1-800-823-9990
(TTY users call 800-777-9083)

Current Members Call:
1-800-818-0007
(TTY users call 800-777-9083)

8:00 a.m. to 8:00 p.m. in your local time zone every day.

www.Universal-American-Medicare.com

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