

# Individual Enrollment Form for 2019

Please contact Express Scripts Medicare® (PDP) if you need information in another language or format (braille).

<b>To enroll in Express Scripts Medicare, please provide the following information:</b>		
Please check which plan you want to enroll in: (For monthly premiums, please see the back of this form.) <input type="checkbox"/> Saver <input type="checkbox"/> Value <input type="checkbox"/> Choice		
LAST Name: <input type="text"/>		
FIRST Name: <input type="text"/>		Middle Initial: <input type="text"/>
Mr. Mrs. Ms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Birth Date: <input type="text"/> M M D D Y Y Y Y	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone: <input type="text"/> - <input type="text"/> - <input type="text"/> Cell Phone: <input type="text"/> - <input type="text"/> - <input type="text"/>
Permanent Residence Street Address (P.O. Box is not allowed): <input type="text"/>		
<input type="text"/>		
City: <input type="text"/>		State: <input type="text"/> ZIP Code: <input type="text"/>
Mailing Address (only if different from your Permanent Residence Address): Street Address: <input type="text"/>		
<input type="text"/>		
City: <input type="text"/>		State: <input type="text"/> ZIP Code: <input type="text"/>
Email Address: <input type="text"/>		
Emergency Contact: <input type="text"/>		
Relationship to You: <input type="text"/>		Phone Number: <input type="text"/> - <input type="text"/> - <input type="text"/>
<b>Please provide your Medicare insurance information:</b>		
<b>Please take out your red, white and blue Medicare card to complete this section.</b>		
<ul style="list-style-type: none"><li>&gt; Fill out this information as it appears on your Medicare card.</li><li>OR</li><li>&gt; Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.</li></ul>		
You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.		
Name (as it appears on your Medicare card): <input type="text"/>		
Medicare Number: <input type="text"/>		
Is Entitled To: <b>HOSPITAL (Part A)</b>		Effective Date: <input type="text"/> M M D D Y Y Y Y
<b>MEDICAL (Part B)</b>		<input type="text"/> M M D D Y Y Y Y



**Please select a premium payment option:**

- Receive a bill: If you would like to pay by credit card or by Electronic Funds Transfer (EFT), please contact us at 1.866.544.2979 when you receive your confirmation of enrollment letter. TTY users should call 1.866.544.2982. Our office hours are 8 a.m. to 9:30 p.m. Eastern, Monday through Friday.
- Automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check.

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)



**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 Express Scripts Medicare, 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 Express Scripts Medicare could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join Express Scripts Medicare. 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.

**Please read and sign on the following page:**

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

Express Scripts Medicare 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 Express Scripts Medicare 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 Express Scripts Medicare 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.

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

Your Signature:  Today's Date: --  
M M D D Y Y Y Y

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

FIRST Name:  Middle Initial:

LAST Name:

Address of Representative (number and street):

City:  State:  ZIP Code:

Phone Number: --

Relationship to Enrollee:

**For applicants receiving assistance from a broker or agent:**

The person who is discussing plans with you is either employed by or contracted with Express Scripts Medicare. The person may be compensated based on your enrollment in a plan.

Broker/Agent Name:

Broker/Agent ID #:

Agency:

Carrier #:  Broker/Agent/Representative Signature:

## Information to determine enrollment periods:

**Typically, you may enroll in a Medicare prescription drug plan only during the Annual Enrollment Period from October 15 through 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 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.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):   -   -
- I recently was released from incarceration. I was released on (insert date):   -   -
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):   -   -
- I recently obtained lawful presence status in the United States. I got this status on (insert date):   -   -
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums), or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):   -   -
- I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):   -   -
- I recently left a PACE program on (insert date):   -   -
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date):   -   -
- I am leaving employer or union coverage on (insert date):   -   -
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I am enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):   -   -
- I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in the level of Medicaid assistance, or lost Medicaid) on (insert date):   -   -

If none of these statements applies to you or you're not sure, please contact Express Scripts Medicare at 1.866.477.5704 to see if you are eligible to enroll. We are open 24 hours a day, 7 days a week (except Thanksgiving and Christmas). To enroll by phone, call between 8 a.m. and 8 p.m., 7 days a week (except Thanksgiving and Christmas). TTY users should call 1.800.716.3231.

## Express Scripts Medicare 2019 premiums:

Region	Service Area	Saver	Value	Choice
01	ME/NH	\$24.00	\$44.10	\$98.00
02	CT/MA/RI/VT	\$24.00	\$35.20	\$94.80
03	NY	\$24.00	\$37.90	\$92.90
04	NJ	\$24.10	\$35.50	\$93.30
05	DC/DE/MD	\$24.00	\$29.20	\$97.20
06	PA/WV	\$25.40	\$36.20	\$100.00
07	VA	\$25.40	\$33.40	\$93.30
08	NC	\$23.90	\$31.10	\$95.20
09	SC	\$25.40	\$43.40	\$96.00
10	GA	\$24.00	\$36.20	\$97.30
11	FL	\$24.10	\$56.70	\$98.90
12	AL/TN	\$24.50	\$30.20	\$87.10
13	MI	\$24.00	\$33.40	\$87.90
14	OH	\$24.00	\$33.60	\$84.40
15	IN/KY	\$24.00	\$31.20	\$87.20
16	WI	\$24.00	\$40.20	\$99.70
17	IL	\$24.00	\$43.10	\$96.80
18	MO	\$24.80	\$46.90	\$95.10
19	AR	\$25.10	\$35.50	\$96.70
20	MS	\$24.50	\$38.40	\$99.90
21	LA	\$24.60	\$31.20	\$88.10
22	TX	\$24.00	\$44.60	\$99.90
23	OK	\$24.00	\$39.50	\$96.80
24	KS	\$24.00	\$43.90	\$99.10
25	IA/MN/MT/ND/NE/SD/WY	\$25.00	\$48.00	\$94.30
26	NM	\$24.00	\$41.90	\$81.50
27	CO	\$24.00	\$51.20	\$94.50
28	AZ	\$24.00	\$32.20	\$98.30
29	NV	\$24.00	\$41.80	\$97.40
30	OR/WA	\$24.00	\$47.20	\$90.00
31	ID/UT	\$24.00	\$39.20	\$93.80
32	CA	\$23.90	\$56.80	\$99.70
33	HI	\$23.90	\$31.50	\$79.00
34	AK	\$24.00	\$33.20	\$97.00
38	PR	\$23.90	\$40.20	NA

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.477.5704 (TTY: 1.800.716.3231).

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.  
Enrollment in Express Scripts Medicare depends on contract renewal.