EXPRESS SCRIPTS®
Medicare (PDP)

Individual Enrollment Form for 2016

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

To enroll in Express Scripts Medicare, please provide the following information:

Please check which plan you want to enroll in: (For monthly premiums, please see the back of this form.)

☐ Value ☐ Choice

LAST Name:

FIRST Name: Middle Initial: Mr. ☐ Mrs. ☐ Ms. ☐

Birth Date: M M - D D - Y Y Y Y

Sex: ☐ M ☐ F

Home Phone Number: - -

Permanent Residence Street Address (P.O. Box is not allowed):

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:

City: State: ZIP Code:

Email Address:

Emergency Contact:

Relationship to You: Phone Number: - -

Please provide your Medicare insurance information:

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.

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.

MEDICARE HEALTH INSURANCE

Name: SAMPLE ONLY Sex:

Medicare Claim Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A) M M - D D - Y Y Y Y

MEDICAL (Part B) M M - D D - Y Y Y Y

Please answer the following 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.

Will you have other **prescription drug** coverage in addition to Express Scripts Medicare?

☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of Other 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: – –

If you would prefer that we send you information in a different language or format, including Spanish or braille, please call Customer Service at 1.866.477.5704. TTY users should call 1.800.716.3231. Our office hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas).

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D Income-Related Monthly Adjustment Amount (Part D–IRMAA), 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 Express Scripts Medicare.

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 coinsurance. 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 doesn't cover.

If you don't select a payment option, you will receive a bill each month.

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 8:00 a.m. to 9:30 p.m., Eastern Time, Monday through Friday.

☐ Automatic deduction from your monthly Social Security/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.)

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 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 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 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/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 information:

Broker/Agent Name:

Broker/Agent ID #:

Agency:

Carrier #:

Medicare prescription drug plan use only:

Plan ID #:

Effective Date of Coverage:	IEP:	AEP:	SEP (type):
M M - D D - Y Y Y Y			

Plan Representative/Agent/Broker 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): M M - D D - Y Y Y Y
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): M M - D D - Y Y Y Y
- ☐ 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 (insert date): M M - D D - Y Y Y Y
- ☐ 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): M M - D D - Y Y Y Y
- ☐ I recently left a PACE program on (insert date): M M - D D - Y Y Y Y
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date): M M - D D - Y Y Y Y
- ☐ I am leaving employer or union coverage on (insert date): M M - D D - Y Y Y Y
- ☐ 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 making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage Plan. I left my Medicare Advantage Plan on (insert date): M M - D D - Y Y Y Y

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 8:00 a.m. and 8:00 p.m., 7 days a week (except Thanksgiving and Christmas). TTY users should call 1.800.716.3231.

Express Scripts Medicare 2016 premiums:

Region	Service Area	Value	Choice
01	ME/NH	$36.90	$82.50
02	CT/MA/RI/VT	$49.00	$72.20
03	NY	$37.30	$70.20
04	NJ	$37.50	$75.70
05	DC/DE/MD	$30.30	$72.00
06	PA/WV	$34.20	$94.40
07	VA	$56.20	$76.90
08	NC	$37.30	$77.20
09	SC	$39.00	$74.40
10	GA	$37.60	$87.00
11	FL	$94.20	$105.00
12	AL/TN	$30.70	$86.90
13	MI	$46.50	$79.60
14	OH	$40.70	$64.90
15	IN/KY	$31.50	$84.10
16	WI	$53.60	$92.70
17	IL	$36.30	$78.40
18	MO	$51.70	$80.10
19	AR	$29.10	$75.70
20	MS	$32.30	$92.10
21	LA	$31.90	$72.00
22	TX	$36.60	$104.30
23	OK	$49.70	$75.50
24	KS	$51.10	$87.40
25	IA/MN/MT/ND/NE/SD/WY	$55.50	$93.70
26	NM	$51.10	$74.00
27	CO	$66.90	$100.00
28	AZ	$33.20	$84.00
29	NV	$68.20	$82.30
30	OR/WA	$38.40	$72.80
31	ID/UT	$40.20	$73.60
32	CA	$60.60	$100.10
33	HI	$31.00	$62.60
34	AK	$51.50	$87.50
38	PR	$52.40	$70.20

You must continue to pay your Medicare Part B premium.

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