F. ENROLLMENT AUTHORIZATION: By completing this enrollment application, I agree to the following:

After carefully reading all statements in this section, please sign Section D of this form. Keep the copy marked "Enrollee" for your records.

1. I understand Group MedicareBlue Rx (PDP) is a Medicare-approved Part D sponsor. Enrollment in Group MedicareBlue Rx depends on renewal of the plan sponsor's contract with Medicare. Coverage is available to members of an employer or union group and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*
   *Independent licensees of the Blue Cross and Blue Shield Association
2. I understand Group MedicareBlue Rx is a Medicare prescription drug plan and 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 Group MedicareBlue Rx of any prescription drug coverage that I have or may get in the future. I can be in only one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Group MedicareBlue Rx will end that enrollment.
3. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year, or under certain special circumstances.
4. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Group MedicareBlue Rx network pharmacies.
5. I understand that once I am a member of Group MedicareBlue Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Group MedicareBlue Rx when I get it to know which rules I must follow to get coverage.
6. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable 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.
7. I understand that benefits, premiums and cost-sharing are subject to change during the employer group's renewal period.
8. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and Blue Shield plans offering Group MedicareBlue Rx, he/she may be paid based on my enrollment in Group MedicareBlue Rx.
9. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
10. **Release of Information:** By joining this Medicare Prescription Drug Plan, I acknowledge that Group MedicareBlue Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations, and as otherwise permitted by law. I also acknowledge that Group MedicareBlue Rx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Group
MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

Group Participant Enrollment Form

RAS1028R07 (09/15) S5743_082415_GB01_RE Internal Approval 08/26/2015

Group MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

GROUP PARTICIPANT ENROLLMENT FORM

INSTRUCTIONS: Please complete all sections of this form. Please read each statement in Section F. Sign and date where indicated in Section D. Return this enrollment form to your employer, union group administrator or other designated contact.

A. PERSONAL INFORMATION (Please Print Clearly):

Group Name: **State of Iowa**	**Group Number:** (check an option) ☐ 38073-$10/$30/$50 (Gen) **Basic** ☐ 38073GOLD-$10/$25/$40 **Plus**		**Requested Effective Date:**
Last Name:	First Name:	Middle Initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth Date: (mm/dd/yyyy) ___/___/___	❑ Male ❑ Female	Home Phone Number: ( ) –	Alternate Phone Number (optional): ( ) –

Permanent Residence Street Address **(no P.O. Box number)**:

City: State: ZIP Code:

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

City: State: ZIP Code:

B. PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please refer to your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card exactly.

- 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:

Medicare Claim Number: – –

Sex:

Is Entitled To: Effective Date (mm/dd/yyyy):

HOSPITAL (Part A) ___/___/___

MEDICAL (Part B) ___/___/___

Distribution: White Copy: Carrier Yellow Copy: Enrollee

C. PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS:

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 Group MedicareBlue Rx (PDP)? ❑ Yes ❑ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: ID number for this coverage: Group number 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 the Institution: _____
   Address and Phone Number of Institution (number and street):
   _____

If you have special needs, alternative formats are available. Please contact Group MedicareBlue Rx Customer Service at **1-877-838-3827**, 8 a.m. to 8 p.m., daily, Central and Mountain Times. TTY users should call **711**.

D. PLEASE READ SECTIONS E AND F 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, including the information in Sections E and F. 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 Group MedicareBlue Rx or by Medicare.

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.

Your Signature: _____ **Today's Date:** _____

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

Name (Print): _____ Phone number: (_____)_____

Address: _____ City: _____ State: _____ ZIP Code: _____

Relationship to Enrollee: _____

❑ I want all mail for this member sent to me.

E. STOP – PLEASE READ THIS IMPORTANT INFORMATION – STOP

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 Group MedicareBlue Rx, 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.