



**Blue Cross MedicareRx<sup>SM</sup> Medicare Prescription Drug Plan Group Employee Enrollment Form**

**To enroll in Blue Cross MedicareRx, please provide the following information:**

Please check the plan you want to enroll in:

- Blue Cross MedicareRx Enhanced Plus (PDP) - Group #2215D4
- Blue Cross MedicareRx Basic (PDP) - Group # 2215D2

Employer: Oklahoma State University Group #: See plan selection above

LAST name: \_\_\_\_\_ FIRST name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  Mr.  Mrs.  Ms.

Birth Date:   /   /     Sex:  M  F Employee ID:

( M M / D D / Y Y Y Y )

Home Phone Number:    -    -     Alternate Phone Number:    -    -

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

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code:

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

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code:

Emergency Contact Name: \_\_\_\_\_

Phone Number:    -    -     Relationship to You: \_\_\_\_\_

Member Email Address: \_\_\_\_\_

**Please Provide Your Medicare Insurance Information**

**Please take out your red, white and blue Medicare card to complete this section.**

- Fill out this information as it appears on your 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 and Part B to join a Medicare prescription drug plan.

Name (as it appears on your Medicare card): \_\_\_\_\_

Medicare Number

Some boxes may be blank.

is Entitled to:

Effective Date: \_\_\_\_\_

**HOSPITAL (Part A)** \_\_\_\_\_

**MEDICAL (Part B)** \_\_\_\_\_

Applicant LAST name: \_\_\_\_\_ FIRST name: \_\_\_\_\_

**Please answer the following questions:**

**1.** Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to Blue Cross MedicareRx?  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 & Phone Number of Institution (number and street):  
\_\_\_\_\_

**Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:**

Spanish

Braille/Large Print

Please contact Blue Cross MedicareRx at 1-877-838-3833 if you need information in another format or language than what is listed above. TTY/TDD users should call 711. Our office hours are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Applicant LAST name: \_\_\_\_\_

FIRST name: \_\_\_\_\_

**Please Read and Sign Below:**

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

Blue Cross MedicareRx 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 Blue Cross MedicareRx 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 Blue Cross MedicareRx 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.

Blue Cross MedicareRx serves a specific service area. If I move out of the area that Blue Cross MedicareRx serves, I need to notify my Employer Group Benefits Office 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 Blue Cross MedicareRx network pharmacies. Once I am a member of Blue Cross MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross MedicareRx 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.

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.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber's Employer Group and Blue Cross and Blue Shield of Oklahoma (BCBSOK), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSOK to use the Blue Cross and/or Blue Shield Service Marks in the State of Oklahoma, and that BCBSOK is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSOK and that no person, entity, or organization other than BCBSOK shall be held accountable or liable to Subscriber for any of BCBSOK's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSOK other than those obligations created under other provisions of this agreement.

**Release of Information:**

By joining this Medicare prescription drug plan, I acknowledge that Blue Cross MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross MedicareRx 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 below), 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.

Applicant LAST name:

FIRST name:

<b>Signature:</b>		<b>Today's Date:</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (M M / D D / Y Y Y Y)	
If you are the authorized representative, you must sign above and provide the following information:			
Name:			
Address:			
Phone Number: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Relationship to Enrollee:	

<b>Office Use Only:</b>			
Plan ID #:		Effective Date of Coverage: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (M M / D D / Y Y Y Y)	
<input type="checkbox"/> ICEP/IEP	<input type="checkbox"/> AEP	<input type="checkbox"/> SEP (type):	<input type="checkbox"/> Not Eligible
Name of staff member/agent/broker (if assisted in enrollment):			
LC:		Referral ID:	

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-299-1008 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-299-1008 (TTY: 711).

This information is not a complete description of benefits. Call 1-877-299-1008 (TTY:711) for more information.

Prescription drug plan is provided by Blue Cross and Blue Shield of Oklahoma, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.

Applicant LAST name:	FIRST name:
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