Blue Cross Group MedicareRx (PDP)℠

Proposed Effective Date:
____ ____ / 0 1 / 2 0 ____ ____
(Must be after enrollee signature date)

Blue Cross Group MedicareRx℠ Medicare Prescription Drug Plan Employee Enrollment Form

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

Please check the plan you want to enroll in:

☐ **PDP Basic**
☐ **PDP Enhanced Plus**

Employer: Oklahoma State University			Group #: 2215D2
Legal LAST Name:	Legal FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ____ ____ / ____ ____ / ____ ____ ____ ____	Sex: ☐ M ☐ F	Employee ID: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____	
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 Street 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 Advantage 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:

All fields for the next two questions are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin.
- ☐ **I choose not to answer**.

All fields for the next two questions are optional. (continued)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Please read and answer these important 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 Group 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 us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Braille/Large Print

Please contact Blue Cross Group MedicareRx at 1-877-838-3833 if you need information in an accessible format or language than what is listed above. TTY 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 Group 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 Group 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 Group MedicareRx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan at any time 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 Group MedicareRx has a service area that includes the United States and its territories. If I move out of the area that Blue Cross Group 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 Group MedicareRx network pharmacies. Once I am a member of Blue Cross Group 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 Group 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 Group 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 Group 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:

Please Read and Sign Below (continued)	
Signature:	**Today's Date:** ___ ___ / ___ ___ / ___ ___ ___ ___
If you are the authorized representative, you must sign above and provide the following information: Name:	
Address:	
Phone Number: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___	
Relationship to Enrollee:	

Office Use Only:			
Plan ID #:			
☐ ICEP / IEP	☐ AEP	☐ SEP (type):	☐ Not Eligible
Name of staff member/agent/broker (if assisted in enrollment):			
LC:		Referral ID:	
Subgroup ID #:		Subgroup Description:	
Class ID #:		Plan ID #:	
Plan Description:			

MAIL APPLICATIONS TO:
OSU Benefits
601 N Willis
PB# 8075
Stillwater, OK 74078
Email: osu-benefits@okstate.edu
FAX APPLICATIONS TO: 405-744-8345

Prescription drug plans provided by 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 plans depends on contract renewal.

Applicant LAST name:	FIRST name: