

Blue Cross MedicareRxSM Medicare Prescription Drug Plan Group Employee Enrollment Form

Please contact Blue Cross MedicareRx if you need information in another language or format (Braille).

Group Number: Please check one box: <input type="checkbox"/> 2215D2 (Basic Plan) <input type="checkbox"/> 2215D4 (Enhanced Plan)
Subgroup/Section Number BA Office Use Only

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

Retiree's Employer Name: Oklahoma State University	Please check which plan you want to enroll in: <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced Plus
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LAST name:	FIRST name:	Middle Initial:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
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Birth Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:
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Emergency Contact:

Phone Number:	Relationship to You:
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E-mail Address:

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.

	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
_____ - _____ - _____	
is Entitled To	Effective Date
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

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 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 a.m. - 8 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.

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 Blue Cross MedicareRx, 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 Blue Cross MedicareRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross MedicareRx. 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 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 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 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Cross MedicareRx, he/she may be paid based on my enrollment in Blue Cross MedicareRx.

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 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.

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:	

Medicare Prescription Drug Plan Use Only:

Plan ID #:				
Effective Date of Coverage:	Date: □□/□□/□□	IEP: _____	AEP: _____	SEP (type): _____
Name of Plan Representative/agent/broker:				
LC:		Referral ID:		

Prescription drug plan 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.