



Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

Regence Life and Health Medicare Script™ Medicare Prescription Drug Plan Individual Enrollment Form

PO Box 12625
Salem, OR 97309-0625
1-888-REGENCE
1-888-734-3623
1 (800) 833-6384 (TTY)

● PLEASE PRINT IN INK ●

Important Information
Please check which plan you want to enroll in:
<input type="checkbox"/> Regence Life and Health Medicare Script \$66.50
<input type="checkbox"/> Regence Life and Health Medicare Script Enhanced \$83.50

Name (Last)	(First)	(M.I.)
--------------	---------	--------

Birthdate (mm/dd/yyyy)	Sex	Social Security Number <small>(providing this information is optional)</small>	Medicare Number
------------------------	-----	---	-----------------

Telephone Number (including area code)	E-mail address
---	----------------

Your Permanent Residence Address			
Number	Street	Apartment	
City	County	State	ZIP Code (+4)

Your Mailing Address (if different from Permanent Address)			
Number	Street	Apartment	
City	County	State	ZIP Code (+4)

Emergency Information		
Name of relative or friend other than spouse	Telephone Number	Relationship to you

Office Use Only					
Effective Date	Election Type	Group #	Pkg #	Alt. ID #	Agent #

Please answer the following question:

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 Regence Life and Health (RLH) Medicare Script?

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 _____

Paying Your Plan Premium

You can pay your plan premium by mail each month or quarterly or by having it deducted from your bank account. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 does not cover.

Please select one plan premium payment option below. If you don't select a payment option, you will receive a bill each month.

Would you like us to automatically deduct your premium from your bank account? Yes No
(A completed SurePay form is required.)

OR

Would you like us to bill you monthly or quarterly? Monthly Quarterly

OR


Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction will begin approximately two months after your enrollment date. We will bill you for your premium until the Social Security deduction begins.) Yes No

Please check the box below, if you would prefer us to send your information in another format:

Large print, audio tape or CD

Please contact Regence Life and Health Medicare Script at 1-800-541-8981 (TTY users should call 1-800-382-1003) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m. seven days a week.

Agent Use Only

Agent Name _____ Agent Signature  _____
(Please print)

Agent Number _____ Agent Phone Number (_____) _____
(including area code)

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 a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining RLH Medicare Script, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. 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 RLH Medicare Script could affect your employer or union health benefits.

If you have health coverage from an employer or union, joining RLH Medicare Script may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Typically, you may enroll in a Medicare prescription drug plan only during the annual enrollment period between November 15 and December 31 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.
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help paying for my Medicare prescription drugs.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I live in or recently moved out of a long term care facility (for example, a nursing home or long term care facility). **Please provide the following information:**

Name of Institution _____

Address and Phone Number of Institution (number and street) _____

- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
- I am leaving employer or union coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- None of these statements applies to me.*

* Please contact RLH Medicare Script at 1-800-541-8981 (TTY users should call 1-800-382-1003) to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., seven days a week.

(Important: Signature required on page 4)

Please read and sign below

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

RLH Medicare Script 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 coverage. It is my responsibility to inform RLH Medicare Script 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 RLH Medicare Script 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 (November 15 - December 31), unless I qualify for certain special circumstances.

RLH Medicare Script serves a specific service area. If I move out of the area that RLH Medicare Script 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 to access RLH Medicare Script benefits, except under limited, non-routine circumstances when I cannot reasonably use RLH Medicare Script network pharmacies. Once I am a member of RLH Medicare Script, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from RLH Medicare Script when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain 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.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with RLH Medicare Script, he/she may be compensated based on my enrollment in RLH Medicare Script. This compensation does not affect my premium in any way.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning 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 RLH Medicare Script will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that RLH Medicare Script 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 behalf of the individual under the laws of the State where the individual resides) 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 RLH Medicare Script or by Medicare.

Your Signature*  _____ Date / /
month/day/year

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

Name _____ Relationship to enrollee _____

Address _____ Phone Number ()
(including area code)