



Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

201 High Street SE
PO Box 12625
Salem, OR 97309

Regence Life and Health Medicare Script™ Plan to Plan Enrollment Form

To make a change in the prescription drug plan you have with Regence Life and Health Medicare Script, fill out the attached plan benefit selection form. Select the plan you would like and sign the form. Then mail the completed form back to us in the enclosed postage-paid envelope.

Please be aware that you can change health plans only at certain times during the year. If you want to switch from one Regence Life and Health Medicare Script plan to another, you can only do so between November 15 and December 31.

Generally, you cannot make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area. If you qualify for extra help with your prescription drug costs, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

Complete the attached form only if you wish to change plans.

If you have any questions, please call our Customer Service Department at 1 (800) 541-8981. TTY users should call 711. From November 15 through March 1 our telephone hours are 8:00 a.m. to 8:00 p.m. seven days a week. After March 1 our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day. Thank you.

(Continue to Page 3)

Regence Life and Health Medicare Script™
(Complete this form only if you wish to change plans)

Member Name (Please Print)

Member Number

I want to transfer from my current plan to the plan I have selected below.

Please check the appropriate line below:

Regence Life and Health Medicare Script Enhanced \$94.50
(\$100 deductible and some coverage during the gap)

Regence Life and Health Medicare Script \$76.50
(\$200 deductible and no coverage during the gap)

Your Plan Premium Options

If you are currently receiving premium bills from us, having your premium deducted from your bank account or from your Social Security check, you can continue to use this method. If you need to change how you pay your plan premium, please contact Customer Service at the telephone number on the back of this form.

If we determine that you owe a late enrollment penalty, your monthly premium will include that amount.

People with limited incomes may qualify for extra help paying their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD user should call 1-877-486-2048.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

(Important: Signature required on next page)



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

Large Print CD Audio Tape

Please contact Regence Life and Health Medicare Script at 1-800-541-8981 (TTY users should call 711) 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 from November 15 through March 1. After March 1 our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day.

Signature*

Date

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

Name

Relationship to Enrollee

Address

Telephone Number

Office Use Only

Effective Date	Election	Code	Group #	Pkg #	Alt. ID #	Agent #

