OMB No. 0938-1378
Expires: 7/31/2024

## Who can use this form?

People with Medicare who want to join a Medicare prescription drug plan.

## To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare prescription drug plan, you must also have either or both:

- Medicare Part A (hospital insurance)
- Medicare Part B (medical insurance)

## When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

## What do I need to complete this form?

- Your Medicare number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

## Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

Send your completed and signed form to:

Arkansas Blue Medicare
P.O. Box 3648
Little Rock, AR 72203

Once they process your request to join, they'll contact you.

## How do I get help with this form?

Call Arkansas Blue Medicare at **1-855-591-9794**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users can call **1-877-486-2048**.

En español: Llame a Arkansas Blue Medicare al **1-855-591-9794**/TTY **711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

## Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

# 2024 Prescription Drug Plan Enrollment Form

## Section 1 - All fields on this page are required (unless marked optional)

## Select the plan you want to join:

**Arkansas Blue Medicare prescription drug plans are available in every county in Arkansas.**

| | | |
|---|---|---|
| ☐ 002 | BlueMedicare Premier Rx (PDP) | $123.90 |
| ☐ 003 | BlueMedicare Value Rx (PDP) | $40.30 |

| First name | Last name | Middle initial |
|---|---|---|
| | | |

| Birth date (MM/DD/YYYY) | Sex | Phone number |
|---|---|---|
| ( / / ) | ☐ M ☐ F | ( ) - |

| Permanent residence street address (don't enter a P.O. Box) | City | County | State | ZIP code |
|---|---|---|---|---|
| | | | | |

| Mailing address, if different from your permanent address (P.O. Box allowed): Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

## Your Medicare information:

**Medicare number:**

- -

| **Medicare Part A effective date** (MM/DD/YYYY): | **Medicare Part B effective date** (MM/DD/YYYY): |
|---|---|
| | |

## Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Arkansas Blue Medicare?

☐ Yes ☐ No

| Name of other coverage: | Member number for this coverage: | Group number for this coverage: |
|---|---|---|
| | | |

## IMPORTANT: Read and sign below:

- I must keep both hosptial (Part A) or medical (Part B) to stay in Arkansas Blue Medicare.
- By joining this Medicare prescription drug plan, I acknowledge that Arkansas Blue Medicare will release my information to Medicare, who may use it to track beneficiary enrollment, for payment, and other purposes applicable to federal statues that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- I understand that except in very limited situations, Medicare does not pay for health services you receive while outside the U.S.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

| Signature: | Today's date: |
|---|---|
| | |

**If you're the authorized representative, sign above and fill out these fields:**

| Name | Address |
|---|---|
| | |

| Phone number | Relationship to enrollee |
|---|---|
| | |

**Typically, you may enroll in a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of this 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). | |
| ☐ I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on | |
| ☐ I recently was released from incarceration. I was released on | |
| ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on | |
| ☐ I recently obtained lawful presence status in the United States. I got this status on | |
| ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on | |
| ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on | |
| ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. | |
| ☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on | |
| ☐ I recently left a PACE program on | |
| ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on | |
| ☐ I am leaving employer or union coverage on | |
| ☐ I belong to a pharmacy assistance program provided by my state. | |
| ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. | |
| ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on | |

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ I dropped a Medicare Supplement insurance (Medigap) policy when I first joined a Medicare Advantage plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I'm joining a drug plan (Part D).

☐ I joined a Medicare Advantage plan with drug coverage when I turned 65. It's been less than 12 months since I joined this plan. I want to switch to Original Medicare, and I'm joining a drug plan.

If none of these statements applies to you or you're not sure, please contact Arkansas Blue Medicare at **1-855-591-9794** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. - 8 p.m. Central, seven days a week, from October 1 - March 31, except for Thanksgiving and Christmas. From April 1 - September 30, our hours are 8 a.m. - 8 p.m. Central, five days a week.

## Section 2 - All fields in this section 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, Puerto Rican
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban
☐ **I choose not to answer.**

What's your race? Select all that apply.

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

Select one if you want us to send you information in a language other than English.

☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Arkansas Blue Medicare at **1-855-591-9794** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. - 8 p.m. Central, seven days a week, from October 1 - March 31, except for Thanksgiving and Christmas. From April 1 - September 30, our hours are 8 a.m. - 8 p.m. Central, five days a week. TTY users should call **711**.

Do you work?

☐ Yes ☐ No

Does your spouse work?

☐ Yes ☐ No

List your primary care physician (PCP), clinic, or health center:

Email address:

I want to get the following materials via email (select one or more):

☐ Annual Notice of Changes (ANOC)
☐ Evidence of Coverage (EOC)
☐ Pharmacy Directory
☐ Formulary (Drug List)

Important plan documents are available for download at arkbluemedicare.com.

## Paying your plan premium

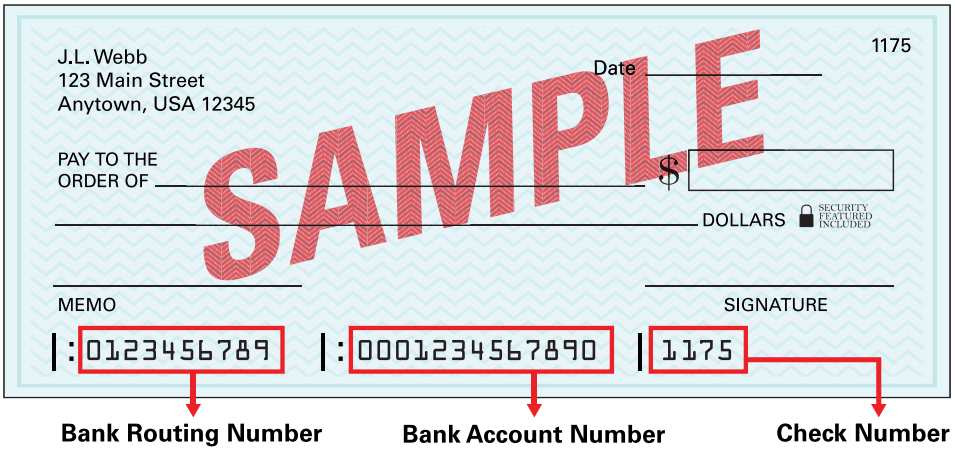
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Arkansas Blue Medicare the Part D-IRMAA.

**Please select a premium payment option**

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

| Bank routing number | Bank account number | Account type<br>☐ Checking ☐ Savings |
|---|---|---|




☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit

**I get monthly benefits from:**

☐ Social Security ☐ RRB

☐ Get monthly bill

Please mail your completed and signed enrollment form to Arkansas Blue Medicare using the postage paid business reply envelope included.

**Office Use Only**

## Arkansas Blue Medicare/Authorized agent

**(individual sales representative/agent who completed the application)**

Agent type (select one): ☐ Authorized agent ☐ ABM employee

| Sales rep/Agent name | Sales rep/Agent NPN # | Agent ID # |
|---|---|---|
| | | |

### PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.