ENROLLMENT APPLICATION

INSTRUCTIONS FOR COMPLETING THIS ENROLLMENT APPLICATION

Read all of the information carefully and answer the questions to the best of your knowledge.

Print neatly and legibly. If you have questions or need assistance filling out this enrollment application, call us at the toll free number listed below and a knowledgeable representative will assist you. Be sure to sign and date the application and return the top copy. The bottom copy should be retained for your own records.

WAYS TO ENROLL

Mail: Fill out the enclosed application and mail it in the envelope we've provided or mail it to the following address:

Senior Markets
Enrollment Department
P.O. Box 535049
Pittsburgh, PA 15253-9801

Phone: Complete your application over the phone toll-free at **1-866-682-7975** (TTY/TDD users may call **711**) from 8:00 AM to 8:00 PM, seven days a week.

Online: Complete your application online at **www.highmarkblueshield.com/medicare**

In person: Bring your application to a Medicare Options Seminar or other authorized locations. Call the toll-free number to find a meeting in your area.

Pennsylvania and West Virginia

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

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

Blue Rx PDP 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 Rx PDP 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 Rx PDP 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.

HM Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in HM Health Insurance Company depends on contract renewal.

Blue Rx PDP serves a specific area. If I move out of the area that Blue Rx PDP 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 Rx PDP network pharmacies. Once I am a member of Blue Rx PDP, 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 Rx PDP 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 Rx PDP, he/she may be paid based on my enrollment in Blue Rx PDP.

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.

PEOPLE WITH LIMITED INCOMES

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.

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 doesn't cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

HIGHMARK®

AGENT & OFFICE USE ONLY

Date Received:	Group Number:	Effective Date:
Agent Name:	Agent NPN:	

In which channel was this application received?

❑ Face to Face Consultation ❑ Medicare Options Seminar
❑ Highmark Direct Store ❑ Member Benefits Forum
❑ Pre-set Home Visit ❑ Other

TO ENROLL IN BLUE RX PDP, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth / /

Home Phone (with area code) ( )

Email Address (if applicable)

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.

Name (as it appears on your Medicare card):

Medicare Number:

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (Part A):

MEDICAL (Part B):

You must have Medicare Part A and Part B (or both) to join a Medicare prescription drug plan.

PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN:

PLEASE MAKE ONLY ONE SELECTION

BLUE RX PDP

❑ Plus – $92.80 per month ❑ Complete – $168.40 per month

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) or on the web with eBill each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill. Information about EFT and eBill will be included with your first bill.

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ❑ Social Security ❑ RRB

(The deduction may take two or more months to begin after approval. In most cases, if approved, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If not approved, we will send you a paper bill for your monthly premiums.)

OTHER INSURANCE

1. Will either you or your spouse be employed once enrolled in Blue Rx PDP? Self: .....Yes ❑ No ❑ Spouse:.....Yes ❑ No ❑

   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____

2. Will you have any Health Insurance and/or Prescription Drug Coverage other than Blue Rx PDP or Medicare that will continue after your enrollment? .....Yes ❑ No ❑

If you answered YES to having any other Health Insurance or Prescription Drug coverage, please provide additional information at the top of the signature page.

RELEASE OF INFORMATION

By joining this Medicare prescription drug plan, I acknowledge that Blue Rx PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Rx PDP 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.

By providing your email address you are allowing for Highmark to contact you by email to provide information about Highmark's current Medicare product offerings, services, and Medicare related events as well as the opportunity to opt in to future email communications from Highmark.

PERSONAL HEALTH INFORMATION

I acknowledge and agree that any "protected health information" (PHI) about me is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Blue Shield's Notice of Privacy Practices is available on Highmark Blue Shield's Web site, or from the Highmark Blue Shield Privacy Department.

PART-D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay the Part D-IRMAA extra amount to Blue Rx PDP.

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

❑ I would like to receive my materials in a language other than English.

❑ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

Please contact Blue Rx PDP at 1-866-682-7975 (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.

Typically, you may enroll in a 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 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.

Annual Enrollment Period (October 15th through December 7th):
If you are enrolling during the annual enrollment period from October 15th through December 7th of each year, and none of the options below apply, we will automatically process your enrollment as part of the Annual Enrollment Period – you do not need to fill out this page.

NEW TO MEDICARE OR A CHANGE TO YOUR COVERAGE

- ❑ 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 had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on_____ (insert date).
- ❑ 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 _____ (insert date).
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).
- ❑ I am leaving employer or union coverage on _____ (insert date).
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

RECENT CHANGE IN RESIDENCE

- ❑ 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 _____ (insert date).
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).
- ❑ I recently was released from incarceration. I was released on _____ (insert date).
- ❑ I recently obtained lawful presence status in the United States. I got this status on _____ (insert date).

CHANGE IN INCOME OR SPECIAL NEEDS/PLAN QUALIFICATIONS

- ❑ 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 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 _____ (insert date).
- ❑ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ I recently left a PACE program on _____ (insert date).
- ❑ I am moving into, 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 _____ (insert date).
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (insert date).

If none of these statements applies to you or you're not sure, please contact Blue Rx PDP at 1-866-682-7975 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m.

Please specify the type of insurance
❑ Active Employer Group Insurance
❑ Retiree Coverage
❑ Veteran's Administration Coverage
❑ Direct Pay Policy
❑ Federal Black Lung Coverage
❑ Supplemental Coverage
❑ Workman's Compensation Coverage

Is this insurance provided by	❑ Your Employer	❑ Your Spouse's Employer	❑ Individual Plan
Does your employer have	❑ 1-19 employees	❑ 20-99 employees	❑ more than 100 employees
Does your spouses' employer have	❑ 1-19 employees	❑ 20-99 employees	❑ more than 100 employees

Your employer's name:_____ Your insurance name:_____

Your insurance policy #:_____ Your insurance group #:_____

Spouse's employer's name: _____ Spouse's insurance name: _____

Spouse's insurance policy #: _____ Spouse's insurance group #:_____

PLEASE ANSWER THE FOLLOWING QUESTION

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): _____

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 prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Blue Rx PDP, 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 Rx PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Rx PDP. 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 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

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 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 Blue Rx PDP or 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:** _____

UPON RECEIPT OF YOUR APPLICATION, A COPY WILL BE RETURNED FOR YOUR RECORDS

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930 。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-844-679-6930.

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-844-679-6930 uffrufe.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930 .

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-844-679-6930.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-844-679-6930 નંબર પર ફોન કરો .

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ ការហៅ 1-844-679-6930 ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930 .

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930. موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-844-679-6930.