EnvisionRxPlus
A MEDICARE APPROVED PRESCRIPTION DRUG PLAN

EnvisionRxPlus (PDP) Medicare Prescription Drug Plan Individual Enrollment Form
Please contact **EnvisionRxPlus** if you need information in another language or format (Braille).

To Enroll in EnvisionRxPlus, Please Provide the Following Information:

LAST Name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (M M/ D D / Y Y Y Y)	Sex: ☐ M ☐ F		Home Phone Number:
Permanent Residence Street Address (P.O. Box is not allowed):			
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
Emergency contact: **Phone Number:** _____ **Relationship to You:**			
E-mail Address:			

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your 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 or Part B (or both) to join a Medicare prescription drug plan.

EnvisionRxPlus is a PDP with a Medicare contract. Enrollment in **EnvisionRxPlus** depends on contract renewal.

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, "Electronic Funds Transfer (EFT)", "credit card" or on-line at www.envisionrxplus.com each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. 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 EnvisionRxPlus.

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. 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.

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.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

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

Account holder name: _

Bank routing number: Bank account number: :

Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card (Visa, MasterCard, Discover, or American Express):

Name of Account holder as it appears on card:

Account number:

Expiration Date: (MM/YYYY)

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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 **EnvisionRxPlus**? ☐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 an accessible format:

_____ Spanish (Español)

_____ Large Print

Please contact **EnvisionRxPlus** at 1-866-250-2005 if you need information in an accessible format or language other than what is listed above. TTY users should call 711. Our office hours are 24 hours a day, 7 days a week.

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 **EnvisionRxPlus**, 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 EnvisionRxPlus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join **EnvisionRxPlus**. 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:

EnvisionRxPlus 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 **EnvisionRxPlus** 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 **EnvisionRxPlus** 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.

EnvisionRxPlus serves a specific service area. If I move out of the area that **EnvisionRxPlus** 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 **EnvisionRxPlus** network pharmacies. Once I am a member of **EnvisionRxPlus**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **EnvisionRxPlus** 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 **EnvisionRxPlus**, he/she may be paid based on my enrollment in **EnvisionRxPlus**.

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.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that **EnvisionRxPlus** will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that **EnvisionRxPlus** 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 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 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: IEP: _[ ]__ AEP: _[ ]_ SEP (type)

Name of Plan Representative/agent/broker:

Date Application Received by Plan: Entered By: Date Entered:

BROKER REQUIRED FIELDS

Name of Agent/Broker: Writing Number (Agent ID):

Requested Effective Date of Coverage: IEP:[ ]_ AEP:[ ]__ SEP:[ ]__

SEP Reason _____

I attest that I have collected the proper Scope of Appointment form signed by this member in accordance with current Medicare Marketing Guidelines: □

Agent/Broker Signature:_____ Date: