

Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. 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 Asuris TruAdvantage?

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 _____

Rx BIN Number _____ Rx PCN Number _____


3. Do you or your spouse work? Yes No

4. Are you currently enrolled in a Asuris Northwest Health individual medical plan or Medicare supplement plan? Yes No

If yes, do you wish to terminate that coverage? Yes No

If you answered "yes" to both of the above questions, please sign the statement below:

I, _____ wish to terminate my
coverage from _____ effective on the date of
this Asuris TruAdvantage policy.

Signature  _____ Date _____

STOP
Please read this important information

If you currently have health coverage from an employer or union, joining Asuris TruAdvantage + Rx or Asuris TruAdvantage + Rx Enhanced could affect your employer or union health benefits.

If you have health coverage from an employer or union, joining Asuris TruAdvantage + Rx or Asuris TruAdvantage + Rx Enhanced 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.

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 SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.) Yes No

Agent Use Only - (The following is a required disclosure to the potential enrollee.)

The person that is discussing plan options with you is either employed by or contracted with Asuris. The person may be compensated based on your enrollment in a plan. This compensation does not affect your premium in any way.

Agent Name _____
(Please print)

Agent Signature  _____

Agent Number _____

Agent Phone Number () _____
(including area code)

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. However, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements and check the box to the left of the statement that applies to you. We will contact you for additional information.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I was recently approved for extra help paying for Medicare prescription drug coverage.
- I just moved "into" a Long Term Care Facility (for example, a nursing home or long term care hospital). **Please provide the following information:**

Name of Institution _____

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

- I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare's).
- I am either losing coverage I had from an employer or leaving employer coverage.
- None of the above statements apply to me.

If you are not sure if any of the above statements applies to you, please contact us to see if you are eligible to enroll.

(Important: Signature required on page 5)

