

# Asuris Medicare Script™

## Medicare Prescription Drug Plan Individual Enrollment Form

• PLEASE PRINT IN INK •

**IMPORTANT** Please check which plan you want to enroll in:

**Asuris Medicare Script**       **Asuris Medicare Script Enhanced**

Name (Last)				(First)				(M.I.)		
Birthdate (mm/dd/yyyy)		Sex	Social Security Number <small>(providing this information is optional)</small>			Medicare Number				
Telephone Number Including Area Code		<b>E-mail address:</b>								
<b>Your Permanent Residence Address:</b>										
Number		Street						Apartment		
City				County			State	Zip Code (+4)		
<b>Your Mailing Address (if different from Permanent Address):</b>										
Number		Street						Apartment		
City				County			State	Zip Code (+4)		
<b>Emergency Information</b>										
Name of relative or friend other than spouse				Telephone Number			Relationship to you			

<b>Medicare Prescription Drug Plan Use Only</b>			
Plan ID #: _____			
Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____			
Agent # _____ Group # _____ Pkg # _____			

**Please answer the following question to help Medicare coordinate your benefits:**

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 Medicare Script?  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

**Paying Your Plan Premium**

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**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? (A completed SurePay form is required.)**  Yes  No

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 with Area Code

## 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 a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Asuris Medicare Script, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. 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 Asuris Medicare Script could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Asuris Medicare Script 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.

Typically, you may enroll in a Medicare prescription drug plan during the annual enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of this period.

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 above statements applies to you, please contact us to see if you are eligible to enroll.

## Please Read and Sign Below

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

Asuris Medicare Script is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Asuris Medicare Script 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 enrolled in a Medicare prescription drug plan, my enrollment in Asuris Medicare Script will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Asuris Medicare Script or by calling 1 (800) Medicare, 24 hours a day/7 days a week. TTY users should call 1 (877) 486-2048.

Asuris Medicare Script serves a specific service area. If I move out of the area that Asuris Medicare Script serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Asuris Medicare Script, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Asuris Medicare Script when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not obtain other Medicare prescription drug coverage or creditable 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.

**Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that Asuris Medicare Script will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Asuris Medicare Script 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 behalf of the individual under the laws of the State where the individual resides) 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 this person is authorized under State law to complete this enrollment.

**Your Signature \*** ➤ \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year

\*If you are the authorized representative, you must provide the following information and attach a copy of proof of Legal Guardianship or proof of authorization by state law.

\_\_\_\_\_  
Name Address

\_\_\_\_\_  
Phone number with Area Code