



201 High Street SE
PO Box 12625
Salem, Oregon 97309

Dear Asuris Medicare Script Member:

To make a change in the prescription drug plan you have with Asuris Medicare Script, fill out the plan benefit selection form on the back of this letter. Select the plan you would like and sign the form. Then mail the completed form back to us in the enclosed postage-paid envelope.

Please be aware that you can change health plans only at certain times during the year. If you want to switch from one Asuris Medicare Script plan to another, you can only do so between November 15 and December 31.

Generally, you cannot make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area. If you qualify for extra help with your prescription drug costs, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

Complete the form on the reverse side of this page only if you wish to change plans.

If you have any questions, please call our Customer Service Department at 1 (800) 541-8981. TTY users should call 1 (800) 382-1003. We are open from 8 a.m. to 8 p.m. seven days a week. Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Susan Nichol".

Susan Nichol, Director
Medicare Membership Accounting

Asuris Medicare Script
(Complete this form only if you wish to change plans)

_____ Member Name (Please Print)

_____ Member number

I want to transfer from my current plan to the plan I have selected below.

Please check the appropriate line below:

_____ Asuris Medicare Script \$64.50
(\$295 deductible and no coverage during the gap)

_____ Asuris Medicare Script Enhanced \$81.00
(No deductible and some coverage during the gap)

Your Plan Premium Options

If you are currently receiving premium bills from us, having your premium deducted from your bank account or from your Social Security check, you can continue to use this method.

If you need to change how you pay your plan premium, please contact Customer Service at the telephone number on the other side of this form.

Signature*: _____ Date: _____

*If you are the authorized representative, you must sign above and provide the following information:

Name _____ Relationship to enrollee _____

Address _____

Phone number _____