2016 SilverScript® Insurance Company

Medicare Prescription Drug Plan Individual Enrollment Form

Please contact SilverScript Insurance Company if you need information in another language or format (Braille).

Section 1: Please Read This Important Information

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period between October 15 and December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment 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 that reason, which will help us to determine your enrollment period.

Reasons for Annual Enrollment Period Eligibility

☐ I am enrolling between 10/15/15—12/7/15 the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I am new to Medicare. ☐ I previously had Medicare but am now turning 65.

Reasons for Special Enrollment Period Eligibility (Select reason and enter date if applicable)

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on __/__/____.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on __/__/____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on __/__/____.

☐ I get Extra Help paying for Medicare prescription drug coverage but do not have Medicaid.

☐ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan with prescription drug coverage for the first time.

☐ In the last 12 months, I turned 65 and joined a Medicare Advantage Plan with prescription drug coverage.

☐ I am (circle one) leaving/losing/joining employer or union coverage on __/__/____.

☐ I received a notice from the Plan/Medicare that I am eligible for a Special Enrollment Period (SEP).

☐ I belong to a Pharmacy Assistance Program provided by my state.

☐ I recently moved outside the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on __/__/____.

☐ I am disenrolling from a Medicare cost plan that I had prescription drug coverage from on __/__/____.

☐ I am being disenrolled from a Medicare Special Needs Plan because I no longer have special needs status as of __/__/____.

☐ I am losing or lost my participation in a Pharmacy Assistance Program provided by my state on __/__/____.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I recently left a PACE program (Program of all inclusive care for the elderly) on __/__/____.

☐ I live in, am moving into, or recently moved out of a nursing home or Long-term Care Facility. I (circle one) moved/will move into/out of this facility on __/__/____.

☐ I am disenrolling from my Medicare Advantage Plan between 1/1/2016 and 2/14/2016 to enroll in original Medicare.

☐ None of these statements apply to me. Please contact SilverScript Insurance Company at 1-855-771-9286, 24 hours a day, 7 days a week. (TTY users call 711).

PLEASE RETURN TO COMPANY

Section 2: To Enroll in SilverScript Prescription Drug Plan, Provide the Following Information

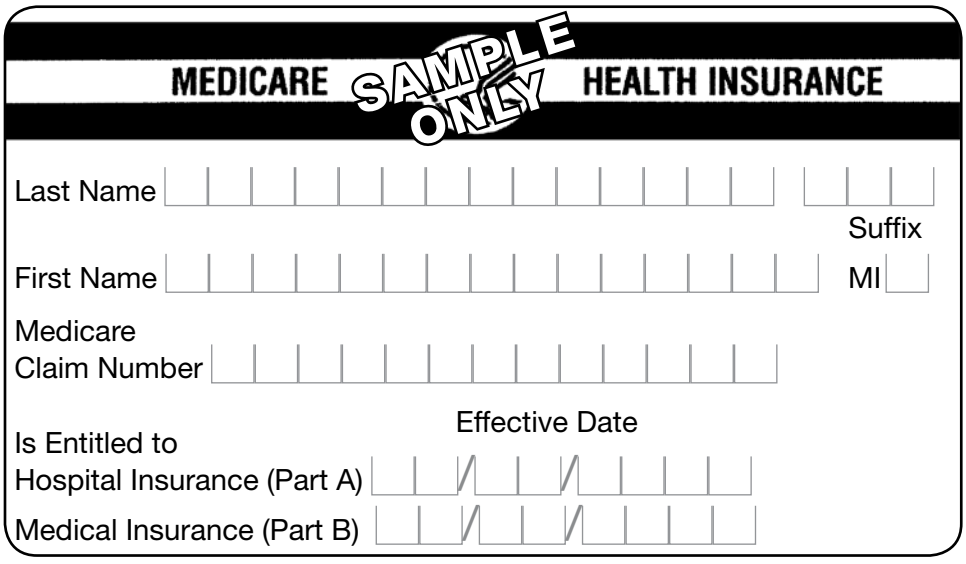
Please check the SilverScript plan in which you wish to enroll.

- ☐ SilverScript Choice (PDP)
- ☐ SilverScript Plus (PDP)

Today's Date M M / D D / Y Y Y Y

Requested Coverage Effective Date M M / D D / Y Y Y Y

Section 3: Complete the Information Below Exactly as it Appears on Your Medicare Card



Use 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.

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

Please Provide the Following Information

Birth Date M M / D D / Y Y Y Y

Sex
- ☐ M
- ☐ F

Primary Phone Number ( ) –

Cell Phone Number ( ) –

Permanent Residence / Long-term Care Facility Address (PO Box is not allowed)

Street Number Street Name

Apt/Suite/Unit

City

County

State

ZIP Code –

Long-term Care Facility Name

Mailing Street Address (only if different from your Permanent Residence Address):

Street Number Street Name

Apt/Suite/Unit

City

County

State

ZIP Code –

E-mail Address (optional)

Section 4: Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check, automatic bank draft withdrawal, credit card, or by mail.

Please select a premium payment option. (If you don't select an option, you will receive a monthly bill.)

☐ **Automatic Deduction from Social Security benefit check**

☐ **Automatic Deduction from Railroad Retirement Board benefit check**

SilverScript will deduct your monthly premium from your Social Security check (or Railroad Retirement Board for those who qualify) automatically. This may take up to 90 days to begin, and will not cover any premiums for which we have already sent you an invoice, so please continue to pay your premium invoice as long as you receive it.

Do not select this option if another entity (such as an Employer Group or State Pharmaceutical Assistance Program) is paying part of your premium.

☐ **Automatic Bank Draft Withdrawal from Checking or Savings Account**

SilverScript will draw your premium from your bank account automatically. To sign up, please send us a VOIDED check and fill in the requested information.

☐ **Checking** ☐ **Savings** **(Check one)**

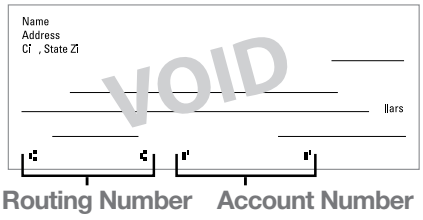
Name on Account

Financial Institution

Routing Number

Account Number

Account Holder Signature _____



By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization named above to pay my premium through electronic bank withdrawal payable to SilverScript Insurance Company. I authorize the deduction of up to $300 at a time (only if the balance is such). The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received.

☐ **Monthly payments by personal check.** You will be mailed a premium invoice each month. **Do not send payment with this enrollment form.**

Note, the option to pay using a **Credit Card** can be started after your enrollment in the plan. You can call us toll free once your enrollment in the plan is active, at: 1-855-771-9286, 24 hours a day, 7 days a week. TTY users call 711.

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 does not cover.

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 SilverScript Insurance Company.

Section 5: Please Read and Answer These Important Questions

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

Do you have other prescription drug coverage in addition to SilverScript Prescription Drug Plan?
☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.
The shaded line shows how this may appear on your card.

Plan Name	Effective Date	Term Date	RxBin	RxPCN	RxGroup	RxID#
ABC Insurance	10/01/2008	12/31/2014	123456	0049876912	ABC1234	123456789

¿Le gustaría recibir esta información en español? ☐ Yes ☐ No

If you need information in an alternate format, such as Braille, audio tape or large print, please contact SilverScript Insurance Company at 1-855-771-9286, 24 hours a day, 7 days a week. (TTY users call 711).

STOP Section 6: Please Read This Important Information STOP

If you are a member of a Medicare Advantage Plan (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining SilverScript 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 SilverScript PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SilverScript PDP. 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.

Section 7: Please Read Terms and Sign on Page 6

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

SilverScript 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 SilverScript 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 SilverScript 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.

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

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 SilverScript PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SilverScript 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.

Applicant's Signature

Your Signature

Print Name *(please print)*

Section 8: Power of Attorney / Authorized Representative

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use)

Name

Address

City **State** **ZIP Code**

Phone Number – –

Relationship to Enrollee ☐ Child ☐ Friend ☐ Spouse ☐ Other

Signature_____ **Today's Date** / /

☐ Please check if authorized representative should receive duplicate copy of plan materials.

STOP **To be Completed by Agent / Prescription Drug Plan Only** STOP

AGENT INSTRUCTIONS:

2 Steps for Successful Enrollment:

Step 1: You must enter the enrollment application into the agent portal within 24 hours of receiving the application from the beneficiary.

Step 2: Please send all pages of the signed, completed application and the Scope of Appointment to SilverScript Insurance Company within 24 hours of portal entry. Choose one of the following options:

☐ **Upload:** Upload a scanned copy of the documents via the agent portal secure mailroom

☐ **Email:** enrollmentverification@CVScaremark.com

☐ **Fax to:** 1-866-552-6205

☐ **Mail:** SilverScript Insurance Company
Attn: Agent Processing
P.O. Box 52134
Phoenix, AZ 85072

Application Received Date / /

Agent ID # _____

Agent Name *(please print)* _____ **Agent Signature** _____

Agent Portal Application Confirmation # _____

SCOPE OF APPOINTMENT (You must check one).

☐ A Scope of Appointment is included with this enrollment form.

☐ A Scope of Appointment was NOT completed because the **application was mailed** to the agent.

When you've completed your Enrollment Form, sign, date, and mail it in the enclosed postage-paid envelope. If you do not use the postage paid envelope, include the proper postage and mail to:

SilverScript Insurance Company
P.O. Box 52067
Phoenix, AZ 85072-9641

Note: not applicable for agent-submitted applications.

You must continue to pay your Medicare Part B premium.

This information is available for free in other languages. Please call our Customer Care number at 1-866-235-5660 (TTY: 711), 24 hours a day, 7 days a week. Esta información está disponible gratuitamente en otros idiomas. Llame a nuestro Cuidado al Cliente, al 1-866-235-5660 (teléfono de texto (TTY): 711), las 24 horas del día, los 7 días de la semana.

SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.