AARP® | MedicareRx Plans
insured through UnitedHealthcare

AARP® MedicareRx Plans Medicare Prescription Drug Plan Individual Enrollment Form

Please contact AARP MedicareRx Plans if you need information in another language or format (Large Print).

To Enroll in One of the 2013 AARP MedicareRx Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ **AARP® MedicareRx Preferred (PDP)** ☐ **AARP® MedicareRx Enhanced (PDP)**

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date:	Sex:	Home Phone Number:
___ ___/__ __/__ __ __ __ __ (M M/ D D/ Y Y Y Y)	☐ M ☐ F	(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	County:	ZIP Code:

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

Street Address: City: State: ZIP Code:

E-mail Address *(optional)*:

Please e-mail me plan information and updates.

Please Provide Your Medicare Insurance Information

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Please take out your red, white and blue Medicare card to complete this section.

- Please fill in these blanks so they match your Medicare card

— **OR** —

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board

An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.

Name: _____

Medicare Claim Number Sex ___

___ ___ ___-___ ___-___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Y0066_PDPSPRJ9904_000 CMS Approved

Name: _____

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 AARP MedicareRx Plans?... ☐ 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): _____

   _____

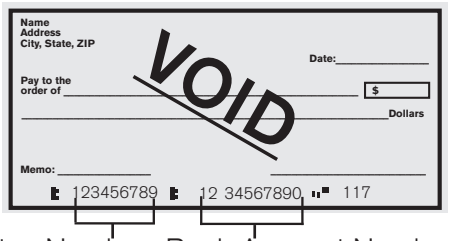
Your Plan Premium Payment Options:

Please select one monthly payment option by checking the appropriate box. If you select the Electronic Funds Transfer option, please include the requested information.

You have three options for paying your monthly premium (including any late enrollment penalty you may owe). You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security or Railroad Retirement Board benefit check, automatically deducted from your checking or savings account through automatic debit, also known as Electronic Funds Transfer (EFT), or you can make your premium payments through a payment coupon book. 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 AARP MedicareRx.

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. If Social Security/the Railroad Retirement Board accepts your request for automatic deduction, premium withholding will not be retroactive and you will be responsible for paying for all premiums due from the enrollment effective date until the month in which premium withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a payment coupon book for your monthly premiums.)

☐ Electronic Funds Transfer (EFT) from your bank account each month (please enclose a blank check with **VOID** written on the front).



Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

☐ Payment coupon book for monthly payments by check

If you don't select a payment option, you will receive a payment coupon book.

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 drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. 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.

Name: _____

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 prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining one of the AARP MedicareRx Plans, 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 a plan sponsor (former employer, union, or trust administrator), you could lose your employer or union health coverage if you join an AARP MedicareRx Plan. Even if your group coverage is with our organization, your enrollment in an individual prescription drug plan could affect or terminate your plan sponsor coverage. In some cases, you may not be able to have your group coverage reinstated. To avoid potential disruption of your current plan coverage, 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:
The AARP MedicareRx Plans are Medicare drug plans and are contracted 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 AARP MedicareRx Plans 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 the AARP MedicareRx Plans 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.

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options or 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 AARP MedicareRx Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AARP MedicareRx Plans 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.

Name: _____

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, 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.

Your Signature:	Today's Date:	SIGNATURE

Authorized Representative Information:

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

Name: _____ Date: _____

Phone: _____ Relationship to Enrollee: _____

Address: _____

Please check one of the boxes below if you would prefer that we send you enrollment information in a language other than English or in another format if available: ☐ Spanish ☐ Large Print

Please contact AARP MedicareRx Plans at **1-866-803-8575** if you need information in another format or language than what is listed above. TTY users should call **711.** Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Broker or Sales Agent Use Only

Sales Agent Signature: _____ Date: _____

Sales Agent Name: Nina Patel Sales Agent ID#: _____

Sales Agent Organization: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Sales Initiative: ☐ Retail/Mall ☐ Community Meeting ☐ Member Meeting

☐ Local B2B Outreach ☐ Local Event Outreach ☐ Other _____

For proper commission processing, please print clearly and include the correct Agent ID#. Agents must be licensed, appointed, and certified to receive commission. Incomplete agent information will cause delays in commission.

AARP MedicareRx Plans Use Only Plan ID#: _____

Employer ID#: _____ Branch ID#: _____

Marketing ID#: _____ Source Code: 740016

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Mail this form to:
UnitedHealthcare, P.O. Box 29200
Hot Springs, AR 71903-9200