Regence
Life and Health Insurance Company
Independent Licensee of the Blue Cross and Blue Shield Association

Regence Life and Health Medicare Script™ (PDP)
Medicare Prescription Drug Plan Enrollment Form

PO Box 12625
Salem, OR 97309-0625
1 (888) 319-8904
TTY 711

● **PLEASE PRINT IN INK** ●

Please provide the following information:

Employer or Trust Name: University of Utah

Please check which plan you want to enroll in:

_____ PDP Option 1

Name (Last)	(First)	(M.I.)

Birthdate (mm/dd/yyyy)	Sex	Medicare Number
– –		

Telephone Number (including area code)	**E-mail Address**
– –	

Your Permanent Residence Address

Number	Street	Apartment

City	County	State	ZIP Code (+4)
			–

Your Mailing Address (if different from Permanent Address)

Number	Street	Apartment

City	County	State	ZIP Code (+4)
			–

Emergency Information

Name of relative or friend other than spouse	Telephone Number	Relationship to you
	– –	

Office Use Only

Effective Date	Election	Code	Group #	Pkg #	Alt. ID #	Agent #

Please continue on next page

Please answer the following question:

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 Regence Life and Health (RLH) 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 Number for this coverage _____

Group Number for this coverage _____

Please check **one** of the boxes below if you would prefer us to send your information in another format:

☐ Large print ☐ CD ☐ Audio Tape

Please contact RLH Medicare Script at 1-888-319-8904 (TTY users should call 711) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m. seven days a week from November 15 through March 1. After March 1 our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day.

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 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.

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 RLH Medicare 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 coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

Employer or Trust Name: University of Utah

Please continue on next page

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 an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.*

☐ I am new to Medicare.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____

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

☐ I get extra help paying for my Medicare prescription drugs.

☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date)_____

☐ I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____

Please provide the following information:

Name of Institution _____

Address and Phone Number of Institution (number and street)

_____

☐ I recently left a PACE program on (insert date) _____

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date)_____

☐ I am leaving employer or union coverage on (insert date) _____

☐ I belong to a pharmacy assistance program provided by my state.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____

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

☐ None of these statements applies to me.*

* Please contact RLH Medicare Script at 1-888-319-8904 (TTY users should call 711) to see if you are eligible to enroll. We are open from 8:00 a.m. to 8:00 p.m., seven days a week from November 15 through March 1. After March 1 our telephone hours are 8:00 a.m. to 8:00 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day.

(Important: Signature required on page 4)

Employer or Trust Name: University of Utah

Please continue on next page

Please read and sign below

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

RLH Medicare Script 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 RLH 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 in a Medicare Prescription Drug Plan, my enrollment in RLH Medicare Script 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.

RLH Medicare Script serves a specific service area. If I move out of the area that RLH Medicare Script 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 RLH Medicare Script network pharmacies. Once I am a member of RLH 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 RLH Medicare Script 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 RLH Medicare Script, he/she may be paid based on my enrollment in RLH Medicare Script. This compensation does not affect my premium in any way.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options and concerning 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 RLH 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 RLH 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 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 RLH Medicare Script or by Medicare.

Your Signature* ▶ _____ Date ___/___/___
month/day/year

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

Name _____ Relationship to enrollee _____

Address _____ Phone Number (___) _____
(including area code)

_____

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Please continue on next page