MASSACHUSETTS

Employer/Broker Only: Receipt date

Blue MedicareRx (PDP) Medicare Prescription Drug Plan

2027 ENROLLMENT FORM

Return completed applications to your employer.
Please refer to the Blue MedicareRx (PDP) Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Please contact Blue MedicareRx (PDP) if you need information in another format or if you'd like information in any languages other than English.

Step 1: Please provide information about you. (Please print clearly.)

Group name: Group number: Requested effective date:

First name: Last name: Middle initial (optional):

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __) Sex: ❑ Male ❑ Female Home phone number:

Permanent residence street address (Don't enter a P.O. Box):

City: State: ZIP code: County (optional):

Mailing address (only if different from your permanent residence address):

Street/P.O. Box: City: State: ZIP code:

Retirement date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)

Step 2: Your Medicare information

Medicare number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Step 3: Signature
Please read the front and back of this application before providing signatures.

I understand that my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) 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 Blue MedicareRx (PDP) or by Medicare.

Signature: Today's date: __ __ / __ __ / __ __ __ __

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

Name:

Phone number: Relationship to enrollee:

Street/P.O. Box: City: State: ZIP code:

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Step 4: Please answer these important questions. All fields in this section are optional.

Do you work? ❑ Yes ❑ No Does your spouse work? ❑ Yes ❑ No

Will you have other prescription drug coverage (like VA, TRICARE®´) in addition to Blue MedicareRx? Yes ❑ No ❑

Name of other coverage:

Group number for this coverage: Member number for this coverage:

Step 5: Please read this important information.

You may only enroll in this plan if you're a retiree or the spouse/dependent of a retiree who qualifies for this Blue MedicareRx (PDP) plan based upon prior employment with the employer or union offering this plan. This plan isn't available to individuals who work enough hours to qualify to enroll in the employer health plans offered to active employees by the employer or union offering this plan.

If you're a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage as part of your Medicare Advantage plan. By joining Blue MedicareRx (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 another employer or union, joining Blue MedicareRx (PDP) could affect your employer or union health benefits. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

Step 6: Application agreement important: Read this information before signing.

- I must keep Hospital (Part A) or Medical (Part B) to stay in Blue MedicareRx (PDP).
- By joining this Medicare Prescription Drug Plan, I acknowledge that Blue MedicareRx (PDP) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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.

Privacy Act Statement:

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (*f*)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Don't send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It won't be kept, reviewed, or forwarded to the plan. See the first page of this document to submit your completed form.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx(PDP) plans. The joint enterprise is a Medicare-approved Part D sponsor.

Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

Blue MedicareRx complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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