

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 UA Medicare Part D? [] 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 # of Institution (number and street): _____



PLEASE READ THIS IMPORTANT INFORMATION



If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining UA Medicare Part D, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. 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 UA Medicare Part D could affect your employer or union health benefits. If you have health coverage from an employer or union, joining UA Medicare Part D may change how your current coverage works. 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.

Please Read And Sign Below

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

UA Medicare Part D is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform UA Medicare Part D 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 UA Medicare Part D will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to UA Medicare Part D or by calling 1-800-MEDICARE, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

UA Medicare Part D serves a specific service area. If I move out of the area that UA Medicare Part D serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of UA Medicare Part D, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UA Medicare Part D when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that UA Medicare Part D will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that UA Medicare Part D will release my information, including my prescription drug event date, 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 behalf of the individual under the laws of the State where the individual resides) 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 UA Medicare Part D or by Medicare.

Your Signature:

Today's Date:

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

Name Relationship to Enrollee

Address Phone # ()

Medicare Prescription Drug Plan Use Only:

Plan ID # Effective Date of Coverage [] IEP [] AEP [] SEP (type)

Agent Signature Agent #

Print first 5 characters of last name

4277126010

A	D	M	7	N	Q	F	8	0	1
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To enroll in UA Medicare Part D, please provide the following information – please print clearly.

LAST Name		FIRST Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date ____/____/____ (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (providing this information is optional)		Home Phone Number ()	
Permanent Residence Street Address				Alternate Phone Number ()	
City		State		ZIP Code	
Mailing Address (only if different from your Permanent Residence Address)					
Street Address		City		State	ZIP Code
Email address					

Please Provide Your Medicare Insurance Information

Please take out 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 the Social Security Administration or Railroad Retirement Board.

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

MEDICARE



HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Claim Number _____ Sex _____

Is Entitled To _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Your Plan Premium Payment Options:

You can pay your monthly premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select ONE premium payment option:

- Receive a monthly bill.**
- Electronic Funds Transfer (EFT) from your bank account each month.**
*If you choose this option, you **must** complete the enclosed Electronic Funds Transfer (EFT) Information Sheet and return it with your completed enrollment form. If we do not receive the Electronic Funds Transfer Information Sheet along with your enrollment form, you will receive a monthly bill.*
- Automatic deduction from your monthly SSA benefit check.**
 (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

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Will you have other prescription drug coverage in addition to UA Medicare Part D? 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: _____

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If you currently have health coverage from an employer or union, joining UA Medicare Part D could affect your employer or union health benefits. If you have health coverage from an employer or union, joining UA Medicare Part D may change how your current coverage works. 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.

Please Read And Sign Below

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I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 UA Medicare Part D or by Medicare.

Your Signature: _____

Today's Date: _____

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

Name _____ **Relationship to Enrollee** _____

Address _____ **Phone #** (_____) _____

Medicare Prescription Drug Plan Use Only:

Plan ID # _____ Effective Date of Coverage _____ IEP AEP SEP (type) _____

Agent Signature _____ Agent # _____

Print first 5 characters of last name _____

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A	D	M	7	N	Q	F	8	0	1
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LAST Name		FIRST Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth Date ____/____/____ (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (providing this information is optional)		Home Phone Number ()	
Permanent Residence Street Address				Alternate Phone Number ()	
City		State		ZIP Code	
Mailing Address (only if different from your Permanent Residence Address)					
Street Address		City		State	ZIP Code
Email address					

Please Provide Your Medicare Insurance Information

Please take out 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 the Social Security Administration or Railroad Retirement Board.

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

MEDICARE



HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Claim Number _____ Sex _____

_____-_____-_____-_____-_____-_____

Is Entitled To _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Your Plan Premium Payment Options:

You can pay your monthly premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select ONE premium payment option:

- Receive a monthly bill.**
- Electronic Funds Transfer (EFT) from your bank account each month.**
*If you choose this option, you **must** complete the enclosed Electronic Funds Transfer (EFT) Information Sheet and return it with your completed enrollment form. If we do not receive the Electronic Funds Transfer Information Sheet along with your enrollment form, you will receive a monthly bill.*
- Automatic deduction from your monthly SSA benefit check.**
 (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)