FOR AGENT USE ONLY — Please complete this form and return it with the enrollment application for Part D

Applicant's Last Name

Applicant's Medicare ID Number

			–			–					–	
			–			–					–	

ENROLLMENT PERIOD QUALIFICATION

Please indicate below which enrollment category qualifies your client for coverage at this time. Also, if they qualify through either Initial Eligibility (Type S2) or under any SEP (Types S3 through S24) below, please note the coverage or SEP Effective Date here:

Coverage or SEP Effective Date (mm/dd/yyyy): _____/_____/_____

TYPE		ENROLLMENT CATEGORIES:
S1	❑	Open Enrollment Period *(November 15 - December 31)*
S2	❑	Initial Eligibility *(due to turning age 65, becoming Medicare eligible, etc.)*
		GENERAL:
S3	❑	Involuntary Loss of Creditable Coverage
S4	❑	Individual Not Adequately Informed of Creditable Coverage availability
S5	❑	Katrina Victim
S6	❑	Change of Permanent Residence
S7	❑	Institutionalized Individual *(confined to a nursing home, skilled nursing, psychiatric, rehab, etc.)*
S8	❑	Currently receiving MEDICAID benefits
S9	❑	Loss of Dual Eligibility *(no longer receiving both Medicare and Medicaid)*
S10	❑	Currently receiving Low Income Subsidy (LIS)
S11	❑	LIS Reinstatement
		ENROLLMENT/DISENROLLMENT:
S12	❑	Employer Group Health Plan *(enrolled in an employer/union sponsored plan)*
S13	❑	Part B General Enrollment Period
S14	❑	Program of All Inclusive Care for the Elderly (PACE) Enrollment/Disenrollment
S15	❑	Federal Employee Error
S16	❑	Centers for Medicare & Medicaid Services (CMS) Facilitated Low Income Subsidy
S17	❑	Medicare Entitlement Determination Made Retroactively
		PRESCRIPTION DRUG PLAN (PDP) RELATED:
S18	❑	Correction - Plan Change
S19	❑	CMS Sanction of PDP
S20	❑	Did not renew 1876 Cost plan contract
S21	❑	PDP Violated Contract Provisions
S22	❑	PDP Did Not Renew Contract
		TERMINATION:
S23	❑	CMS Terminated PDP Sponsor Contract
S24	❑	PDP Terminated Contract

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION SHEET

Medicare Part D Prescription Drug Coverage

In order to have your monthly premiums deducted from your bank account, this form must be completed and returned along with your enrollment form.

If you do not choose to have the monthly premium for Part D automatically deducted from your Social Security check, you can opt to pay your premium via Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you choose Electronic Funds Transfer (EFT), we will automatically draft your Medicare prescription drug plan premiums each month from the bank account you designate.

If you choose to have your premiums deducted monthly from your checking account, please be sure to attach a personalized voided check.

Applicant's Last Name

Applicant's Medicare ID Number ___ - ___ - ____ - ____ - ___

Account Type ☐ Savings ☐ Checking

Bank Draft Day* ___

Bank Routing Number

Bank Account Number

** Day of the month you want your account to be drafted – 01 to 28 only. NOTE: If the Draft Day you select is the 18th or later, your Part D premium will be drafted in the month prior to your due date.*

If we will be deducting your premium from your checking account, please TAPE personalized VOIDED CHECK here.

DO NOT STAPLE.

AUTHORIZATION: I authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United American Insurance Company. This authorization is to remain in effect until revoked by me in writing. All premiums/fees may be automatically withdrawn from my account on a MONTHLY basis.

Account Holder's Signature (as it appears on financial institution records)

Please sign here!

S5755_08EFTINFO
CMS Approval Date 08-06-2007