

AARP<sup>®</sup> MedicareRx Plans Medicare Prescription Drug Plan Individual Enrollment Form

To enroll in one of the 2009 AARP MedicareRx Plans, please provide the following:

Check the ONE plan you want to enroll in:

AARP MedicareRx Preferred     AARP MedicareRx Enhanced

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Mr.  
 Mrs.  
 Ms.

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
 (MM/ D D/ Y Y Y Y)    Applicant Social Security Number: \_\_\_\_\_  
 (providing this information is optional)    Home Phone Number: \_\_\_\_\_  
 (\_\_\_\_) \_\_\_\_\_

Permanent Residence Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (only if different from your Permanent Residence Address):  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
 Contact Phone Number: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

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 the Social Security Administration or 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) \_\_\_\_\_

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: _____
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2. Do you, on your own or through your spouse, have any additional primary, supplemental or liability plan other than Medicare that includes prescription drug coverage?.....  Yes  No

3. 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 Facility: \_\_\_\_\_

Address & Phone Number of Facility: \_\_\_\_\_

Plan information is available in different formats, including Spanish and large print. Please call UnitedHealthcare Customer Care at 1-888-867-5564, 24 hours a day, 7 days a week, TTY 1-877-730-4192, if you need plan information in another format or language.

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. You can have the monthly premium for this Medicare drug plan automatically deducted from your checking or savings account through automatic debit, also known as Electronic Funds Transfer (EFT), can make your premium payments through a payment coupon book, or can have the premium automatically deducted from your Social Security check.

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

Account Holder Name: \_\_\_\_\_

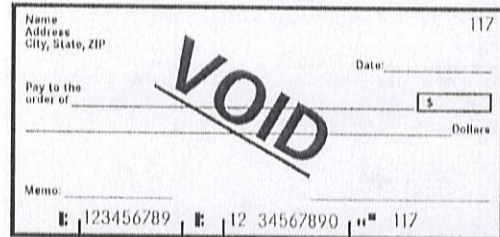
Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Account Type:  Checking  Savings

Payment coupon book for monthly payments by check.

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)



Bank Account Number  
Bank Routing Number

**If no option is chosen, you will receive a payment coupon book.**

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose an option above for paying the remaining premium, if there is any.

**STOP Please Read This Important Information**

**The person who is discussing plan options with you is either employed by or contracted with the plan he or she is describing. The person may be compensated based on your enrollment in a plan.**

**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 help meet your needs. By joining one of the AARP MedicareRx Plans, your membership in your Medicare Advantage plans 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 or prescription drug coverage from a plan sponsor (former employer, union, or trust administrator)**, enrollment in this plan could either change how your current coverage works or terminate your group plan if your group coverage includes Medicare Advantage, Medicare Advantage Prescription Drug or a prescription drug 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 group plan coverage, please discuss your intent to enroll in an individual prescription drug plan with your group administrator and ask what their rules are concerning individual prescription drug plan enrollment.

**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 coverage. It is my responsibility to inform the 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 to 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 Election Period (November 15 to December 31), unless I qualify for certain special circumstances.

The AARP MedicareRx Plans serve a specific service area. If I move out of the area that the 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 to access AARP MedicareRx Plan benefits, except under limited, non-routine circumstances when I cannot reasonably use AARP MedicareRx Plan network pharmacies. Once I am a member of the 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 the AARP MedicareRx Plans 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.

If applying for the AARP MedicareRx Enhanced plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with AARP MedicareRx Plans he/she may be compensated 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 and concerning Medical Assistance through the state Medicare program and the Medicare Savings Program.

**Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that the 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 the 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.

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 the AARP MedicareRx Plans or by Medicare.

Your Signature: _____	Today's Date: _____	
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**If applicant is unable to sign, witness signature is required**

Witness Signature: <i>(If applicant is unable to sign)</i> _____	Today's Date: _____	Telephone Number: _____
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**Authorized Representative Information**

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign below and provide the following information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Enrollee: \_\_\_\_\_

**Broker or Sales Agent Use Only**

Sales Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Sales Agent Name: Alan Sheketoff Sales Agent ID#: 203/278  
Sales Agent Organization: Macman Insurance Associates

*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#: \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_ IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_  
Employer ID#: \_\_\_\_\_ Branch ID#: \_\_\_\_\_  
Marketing ID#: \_\_\_\_\_ Source Code: P09AGT  
Plan Representative Signature: \_\_\_\_\_