Independence
Select Option® PDP

MEDICARE PRESCRIPTION DRUG PLAN EMPLOYER GROUP ENROLLMENT AND CHANGE FORM

Please contact Select Option PDP if you need information in another language or format (Braille).

Easy step-by-step instructions for filling out this Select Option® PDP enrollment form

SECTION A Personal Information — Provide the personal information requested. Then check the box in front of your requested action and provide information about your employer or union.

SECTION B Medicare Insurance Information — Use your Medicare card to complete this section.

SECTION C Important Questions — Please answer the questions in this section.

SECTION D Your Signature — Please read the information provided, then sign and date your enrollment form. If you are an authorized representative, please provide the information requested.

QUESTIONS?

Call toll-free **1-866-319-5777**
Speech- or hearing-impaired: **711**
Seven days a week, 8 a.m. to 8 p.m.
www.ibxmedicare.com

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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A To enroll in Select Option PDP, please provide the following information:

LAST Name: FIRST Name: Middle Initial:

Birth Date: (__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

Sex: ☐ M ☐ F

☐ Mr. ☐ Mrs. ☐ Ms.

Phone Number: ( )

Email Address (optional): _____

By voluntarily giving Independence Blue Cross my phone number (including my mobile number) and/or email address, I authorize Independence Blue Cross and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via email, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy.

Permanent Residence Street Address (P.O. Box is not allowed):

City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency Contact: _____

Phone Number: ( )

Relationship to You:

Requested Action:

ADDITIONS
☐ New Subscriber

CHANGES
☐ Name ☐ Address ☐ Other

Employer/Union:

Name of Employer/Union (Past or Present): _____

_____

Group #: _____

Desired Effective Date: (__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

B Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	(__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)
MEDICAL (Part B)	(__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)

You must have Medicare Part A and Part B to join a Medicare prescription drug plan.

C Please answer the following questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to *Select Option PDP*? ☐ Yes ☐ No

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 Number of Institution (number and street): _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Other language (please specify) _____
☐ Braille
☐ Audio tape
☐ Large Print
☐ Data CD

Please contact Select Option PDP at 1-866-319-5777 if you need information in another format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY/TDD users should call 711. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

Please read this important information before you continue

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 *Select Option 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 benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

D Please read and sign below:

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

Select Option PDP is a PDP plan with a Medicare contract. Enrollment in *Select Option PDP* depends on contract renewal. 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 *Select Option PDP* of any prescription drug coverage that I have or may get in the future. I can only be in one prescription drug plan at a time — if I am currently in a Medicare Prescription Drug Plan, my enrollment in *Select Option PDP* 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 only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use *Select Option PDP* network pharmacies. Once I am a member of *Select Option PDP*, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from *Select Option PDP* 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 *Select Option PDP*, he/she may be paid based on my enrollment in *Select Option PDP*. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, 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 *Select Option PDP* will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that *Select Option PDP* will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 the laws of the state 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 from Medicare.

☐ Please check this box to confirm that you are a retiree.

Underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

Signature:	Today's Date: (____/____/________) (M M / D D / Y Y Y Y)

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

Name: _____

Address: _____

Phone Number: ( )

Relationship to Enrollee: _____

Office Use Only

Group #: _____ Group Name: _____

Desired Effective Date of Coverage: _____ Disenroll Date: _____

Plan Representative Signature: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Top Account: _____ Sub Account: _____

Benefit Plan ID: _____ Benefit Package ID: _____