2024
Group MedicareBlue℠ Rx (PDP) Participant Enrollment Form

Fill out the enrollment form and mail or fax to:

Group MedicareBlue Rx
PO Box 981705
El Paso, TX 79998-1705

Fax: 1-855-658-2709

Group MedicareBlue℠ Rx (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Group MedicareBlue Rx depends on renewal of the plan sponsor's contract with Medicare. Coverage is available to members of an employer or union group and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa*; Blue Cross and Blue Shield of Minnesota*; Blue Cross and Blue Shield of Montana*, a division of Health Care Service Corporation, a Mutual Legal Reserve Company; Blue Cross and Blue Shield of Nebraska*; Blue Cross Blue Shield of North Dakota*; Wellmark Blue Cross and Blue Shield of South Dakota*; and Blue Cross Blue Shield of Wyoming*.

*Independent licensees of the Blue Cross and Blue Shield Association

Group MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

S5743_081123_K02_C

OMB No. 0938-1378
Expires: 7/31/2024

Group MedicareBlue Rx Participant Enrollment Form

To enroll in Group MedicareBlue Rx, please provide the following information and this enrollment form to your employer group or other designated contact.

A. Personal information (please print clearly)

Group name:		Group number:	**Requested effective date:**
State of Iowa	$5/$10/20%/45%/33%	38073	

Last name: First name: Middle initial:

Email address (optional):

Birth date:	❑ Male ❑ Female	Home phone number:	Alternate phone number (optional):
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Permanent residence street address **(P.O. Box not allowed)**:

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:

City:	State:	ZIP code:

Billing address, if different from your permanent address (P.O. Box allowed):

Street address:

City:	State:	ZIP code:

B. Please provide your Medicare insurance information

Medicare number: ☐☐☐☐ – ☐☐☐ – ☐☐☐☐

Is entitled to: Effective date (MMDDYYYY):

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 or Part B (or both) to join a Medicare prescription drug plan.

Enrollee name: _____

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C. Please answer the following questions to help Medicare coordinate your benefits

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 Group MedicareBlue Rx (PDP)?

❑ Yes ❑ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

D. Enrollment authorization: By completing this enrollment application, I agree to the following:

IMPORTANT: Read and sign below

- I must keep Hospital (Part A) or Medical (Part B) to stay in Group MedicareBlue Rx.
- By joining this Medicare prescription drug plan, I acknowledge that Group MedicareBlue Rx 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 on page 4).
- 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.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature: _____ **Today's date:** _____

If you are the **authorized representative,** you **MUST** sign above and provide the following information:

Name (Print): _____ Phone number: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Relationship to enrollee: _____

❑ I want all mail for this member sent to me.

All fields on this page are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in an accessible format.

❑ Braille ❑ Large print ❑ Audio CD

Please contact Group MedicareBlue Rx at **1-877-838-3827** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., daily, Central and Mountain times. TTY users can call **711**.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

❑ No, not of Hispanic, Latino/a, or Spanish origin
❑ Yes, Mexican, Mexican American, Chicano/a
❑ Yes, Puerto Rican
❑ Yes, Cuban
❑ Yes, another Hispanic, Latino/a, or Spanish origin
❑ **I choose not to answer.**

What's your race? Select all that apply.

❑ American Indian or Alaska Native
❑ Asian Indian
❑ Black or African American
❑ Chinese
❑ Filipino
❑ Guamanian or Chamorro
❑ Japanese
❑ Korean
❑ Native Hawaiian
❑ Other Asian
❑ Other Pacific Islander
❑ Samoan
❑ Vietnamese
❑ White
❑ **I choose not to answer.**

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 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 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 (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.