

2026 Group MedicareBlueSM Rx (PDP) Participant Enrollment Form

Fill out the enrollment form and mail or fax to:

Group MedicareBlue Rx
PO BOX 31049
Tampa, FL 33631

Fax: 1-855-658-2709

Group MedicareBlueSM 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



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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:																
Last name:		First name:	Middle initial:																
Email address (optional):																			
Birth date: <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>									M	M	D	D	Y	Y	Y	Y	☐ Male ☐ Female	Home phone number:	Alternate phone number (optional):
M	M	D	D	Y	Y	Y	Y												
Permanent residence street address (P.O. Box not allowed. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):																			
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: <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> - <table border="1"><tr><td></td><td></td><td></td></tr></table> - <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>																	
Is entitled to:	Effective date (MMDDYYYY):																
HOSPITAL (Part A)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>									M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y										
MEDICAL (Part B)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>									M	M	D	D	Y	Y	Y	Y
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: _____

OMB No. 0938-1378

Expires: 6/30/2026

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 7).
- 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.

Enrollee name: _____

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All fields on this page are optional.

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

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data 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**.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center: _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

Notice of Availability

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-838-3827 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-838-3827 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-838-3827 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-838-3827 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-838-3827 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-838-3827 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-838-3827 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-838-3827 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-838-3827 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-838-3827 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-838-3827. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-838-3827 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-838-3827 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-838-3827 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-838-3827 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-838-3827 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-838-3827 (TTY: 711) にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

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.