UPMC *for Life*

UPMC Health Plan Medicare Program

How to Enroll in the UPMC *for Life* PRESCRIPTION DRUG PLAN (PDP) APPLICATION INSTRUCTIONS

General Instructions:
Please fill out each section of the enclosed application completely. **All information must be completed and the application signed, in order for your enrollment form to be processed.**

If you would like assistance with your UPMC *for Life* Prescription Drug Plan (PDP) Enrollment Application or have questions about your enrollment, please contact us at 1-877-381-3765, seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call 1-800-361-2629.

> **Note:** From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

You may enroll in a Medicare Prescription Drug Plan **ONLY** during the annual enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Section 1 – Name and Address Information: Complete your name and address information. The permanent address field must be your physical street address. Please do not list a P.O. box address in the permanent address field.

Section 2 – Medicare Information: Provide your name, Medicare Claim number, and effective dates (Parts A and/or B) exactly as they appear on your red, white, and blue Medicare identification card. You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan. Your application cannot be finalized until UPMC *for Life* has your Medicare Claim number and effective dates of coverage.

Section 3 – Select a Plan Premium Payment Option: Select the method by which you would like to pay your premium.

Sections 4 and 5 – Other Health Insurance Information and Questions: If you have other prescription drug coverage, please provide this information. Also, provide answers to the questions in Section 5 regarding long-term care facility residence.

Sign and Date the Application: After you have read the UPMC *for Life* Rights and Responsibilities statements carefully and completed the enrollment application, please sign and date the application where indicated.

S3389_S8201_09_027 (08/2008)

2009 MC INDV PDP ENRLMT INST FY C20080811-15 (RT)P 9/22/08 4.01M SS

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UPMC *for Life* PRESCRIPTION DRUG PLAN (PDP) Pennsylvania and West Virginia - 2009

UPMC *for Life* Rights and Responsibilities
By completing this enrollment application I agree to the following statements:

(a) **I understand that if I am in a Medicare Advantage Plan (like an HMO or PPO), I may already have a prescription drug benefit from my Medicare Advantage Plan that will meet my needs.** By joining UPMC *for Life* Prescription Drug Plan, it means that membership in my Medicare Advantage plan may end and this will affect both my doctor and hospital coverage. I don't have to do anything to cancel membership in my Medicare Advantage plan. By joining UPMC *for Life* Prescription Drug Plan, I will now get my health care from Original Medicare or a PFFS plan and Medicare prescription drugs from UPMC *for Life* Prescription Drug Plan.
(b) I understand that if I currently have health coverage from an employer group or union, joining UPMC *for Life* Prescription Drug Plan could change how my current coverage works. I will read the communications my employer group or union sends me. If I have questions, I will visit their website or contact the office listed in their communications. If there is no information on whom to contact, I will contact the plan benefits administrator.
(c) UPMC *for Life* is a Medicare drug plan and has a contract 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 UPMC *for Life* 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 in UPMC *for Life* will end that enrollment.
(d) I understand that enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes ONLY if an enrollment period is available (generally during the Annual Enrollment Period from November 15 – December 31), unless I qualify for certain special circumstances.
(e) 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.
(f) UPMC *for Life* Prescription Drug Plan serves a specific service area. If I move out of the area that UPMC *for Life* serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
(g) Once I am a member of UPMC *for Life*, I have the right to appeal plan decisions about payment or prescriptions if I disagree. I will read the Evidence of Coverage document from UPMC *for Life* when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
(h) I understand that if I choose to receive covered prescriptions from a pharmacy outside of the UPMC *for Life* network, those prescriptions may result in higher out-of-pocket costs. If I use an out-of-network pharmacy, I must pay the full cost of the prescription at the point of sale and will need to submit a paper claim for payment.
(i) I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with UPMC *for Life*, he or she may be compensated based on my enrollment in this plan.
(j) 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 Medicaid (Medical Assistance) program and the Medicare Savings Program.
(k) <u>Release of Information:</u> By joining this Medicare Prescription Drug Plan, I acknowledge that UPMC *for Life* Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UPMC *for Life* will release my information, including my prescription drug event data (if applicable), to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

Continued

Please read the following statements carefully and check all of the boxes to the left of the statements that apply to you. By checking any of the boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled. If you have questions about your enrollment in our Plan contact UPMC *for Life* at the phone numbers provided below.

☐ **I am new to Medicare.**

☐ **I am either losing or leaving my employer or union group coverage.**

☐ **I recently moved outside of the service area of my current plan.**

☐ **I recently moved and this plan is a new option for me.**

☐ **I recently returned to the United States after living permanently outside of the U.S.**

☐ **I live in or recently moved out of a long-term care facility (e.g., nursing home).**

☐ **I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.**

☐ **I recently left a Program for All Inclusive Care for the Elderly.**

☐ **I receive extra help paying for Medicare prescription drug coverage.**

☐ **I belong to a pharmacy assistance program provided by the state (e.g., PACE).**

☐ **I recently left a pharmacy assistance program (e.g., PACE).**

☐ **I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare).**

☐ **I am no longer eligible for extra help paying for my Medicare prescription drugs.**

☐ **None of these statements apply to me.**

Please check one of the boxes below if you would prefer us to send you information in an alternative format or contact our Plan for another format, not listed, at the phone numbers provided below:

☐ Language, other than English; please list ______________________________

☐ Large Print ☐ Braille ☐ Audiotape

For questions about this application call UPMC *for Life* at 1-877-381-3765, seven days a week from 8 a.m. to 8 p.m. TTY/TTD users should call 1-800-361-2629. (From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.)

UPMC *for Life*

UPMC Health Plan Medicare Program

2009 MEDICARE PRESCRIPTION DRUG PLAN (PDP) INDIVIDUAL ENROLLMENT APPLICATION

Pennsylvania and West Virginia
Contract Number: S3389

If you have questions about this form, please call us at 1-877-381-3765. TTY/TDD users should call 1-800-361-2629.

OFFICE USE ONLY	
Plan ID#:	Effective Date:
ICEP/IEP:	OEP:
AEP:	SEP (type):
Not Eligible:	
Prior Plan, if applicable:	
Plan Representative/Broker:	
If you assisted with application, sign and date below.	
Application Mailed: ❑	Faxed: ❑

I. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name: First M.I. Last			Telephone #: ( )	
Date of birth: / /	☐ Male ☐ Female	Social Security #: *(Optional)*		
Permanent address (Street, Apartment #):	City:	State:	Zip code:	County:
Mailing address (Street, Apartment #):	City:	State:	Zip code:	County:
E-mail address: (*Optional*):				

2. MEDICARE INFORMATION

Please fill in the card to the right with the information from your Medicare card. Otherwise, please attach a copy of your Medicare card or your Letter of Verification from Social Security (or from the Railroad Retirement Board). You must have Medicare Part A or B (or both) to join our Plan. **We cannot consider your enrollment finished until you have given us this information.**

MEDICARE HEALTH INSURANCE

Sample Only

Name of beneficiary: ____________________

Medicare claim number: ____________________

Is entitled to: Effective date:

☐ Hospital Insurance (Part A) ____________

☐ Medical Insurance (Part B) ____________

3. SELECT A PLAN PREMIUM PAYMENT OPTION

PLAN PREMIUM INFORMATION

We will send you a bill each month which you can pay by check, Electronic Funds Transfer (EFT), or credit card. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

I would like to pay my monthly plan premium (if applicable) by:

☐ **Check** ☐ **EFT** ☐ **Credit Card**

If you elected to pay your premium by credit card or EFT, please complete the enclosed Payment Election Form and return it with your application.

☐ **Automatic deduction from my monthly Social Security benefit check.**
(The Social Security deduction, if approved, 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.)

Note: If you qualify for extra help with your Medicare prescription drug coverage costs and Medicare only pays a portion of this premium, we will bill you for the portion that Medicare does not cover.

4. 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 (e.g., PACE).

Will you have other prescription drug coverage in addition to UPMC *for Life* PDP? . . . . ☐ Yes ☐ No

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

Insurance company name:	ID number:
Insurance company phone:	Group number:
Subscriber name:	Subscriber date of birth:

5. PLEASE READ AND ANSWER THIS QUESTION

Your answers to the following question will NOT keep you from enrolling in this plan.

(a) Are you a resident in a long-term care facility, such as a nursing home? . . . . ☐ Yes ☐ No

(b) **I completed this application with assistance from a UPMC Health Plan representative.**

☐ **face-to-face meeting** ☐ **telephone call** ☐ **completed by myself**

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 reside) 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 UPMC *for Life* or by Medicare. **Your signature on this application means that you have reviewed and understand the plan benefits/premium and Rights and Responsibilities listed at the beginning of this form.**

Signature:____ Date:______________

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

Name: ____

Relationship to enrollee: ____

Address: ____

Phone number: ____

Please return the **WHITE COPY** to UPMC *for Life* in the **postage-paid envelope** provided. **Please keep the Yellow Copy for your records.** Or you can fax the information to UPMC *for Life* at 412-454-7766. Our mailing address is UPMC *for Life*, P.O. Box 2967, Pittsburgh, PA 15230.

White copy to: UPMC *for Life* **Yellow copy to:** Member