

**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 here: |                            |             |
| Application Mailed: _____ Faxed: _____                |                            |             |

| I. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION                                      |   |   |                          |
|---|---|---|--------------------------|
| Name: First   | M.I.  | Last  | Home telephone #:<br>( ) |
| Date of birth: / /  | Sex:<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Alternate telephone # (optional):<br>( )  |                          |
| E-mail address: (optional):   |   | Do we have your permission to send you information (e.g., newsletters, health information) via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |
| Permanent address (Street, Apartment #): <i>P.O. Box is not allowed.</i>                    |   |   |                          |
| City:   | State:  | Zip code:   | County:                  |
| Mailing address (Street, Apartment #): <i>Complete if different from permanent address.</i> |   |   |                          |
| City:   | State:  | Zip code:   | County:                  |

| 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 from Social Security or from the Railroad Retirement Board. You must have Medicare Parts A and B (or both) to join our Plan. <b>We cannot consider your enrollment complete until you have given us this information.</b> |

| MEDICARE HEALTH INSURANCE                            |                 |
|--|-----------------|
| Sample Only  |                 |
| Name of beneficiary:                                 | _____           |
| Medicare claim number:                               | _____           |
| Is entitled to:                                      | Effective date: |
| <input type="checkbox"/> Hospital Insurance (Part A) | _____           |
| <input type="checkbox"/> Medical Insurance (Part B)  | _____           |

### 3. SELECT A UPMC *for Life* PREMIUM PAYMENT OPTION

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 benefit 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.)*

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance.

Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

**Note:** If you qualify for extra help with your Medicare prescription drug coverage costs and Medicare only pays a portion of your plan premium, we will bill you for the amount that Medicare doesn't cover.

### 4. OTHER HEALTH INSURANCE INFORMATION

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).

1) Will you have other prescription drug coverage in addition to UPMC *for Life*?    Yes    No

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

Insurance company name:

Subscriber name:

ID number:

Group number:

Subscriber date of birth:

Insurance company phone:

### 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

If "yes" please provide the following information:

Name of Institution: \_\_\_\_\_

Address of Institution: \_\_\_\_\_

Phone number of Institution: \_\_\_\_\_

## 6. INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD

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 number provided on page 1 of this application.

|   |   |
|---|---|
| <input type="checkbox"/> I am new to Medicare.  | <input type="checkbox"/> I recently left a Program for All Inclusive Care for the Elderly on (insert date) _____.   |
| <input type="checkbox"/> I am either losing or leaving my employer or union group coverage on (insert date) _____.  | <input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage.   |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.             | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state (e.g., PACE).   |
| <input type="checkbox"/> I recently moved and this plan is a new option for me.   | <input type="checkbox"/> I recently left a pharmacy assistance program (e.g., PACE) on (insert date) _____.   |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.                                   | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____. |
| <input type="checkbox"/> I am moving into, live in, or recently moved out of a long-term care facility (e.g., nursing home). I moved/will move into/out of the facility on (insert date) _____. | <input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.                     |
| <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.  | <input type="checkbox"/> None of these statements apply to me.  |

## 7. ALTERNATIVE FORMAT OPTIONS

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* at the phone number provided on page 1 of this application.

Audio       Large Print       Braille       Language (please list) \_\_\_\_\_

**Release of Information:** By joining this Medicare Prescription Drug Plan, I acknowledge that UPMC *for Life* 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, to Medicare, which 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 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.**

I completed this application with assistance from a UPMC Health Plan representative.

Face-to-face meeting       Telephone call       Completed by myself

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Verification call number:**

Please call me to verify my enrollment at the telephone number I provided on page 3 of the application or the number provided below:

Home number       Alternate number       Telephone number listed: \_\_\_\_\_

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 Duplicate Copy for your records.**

# UPMC *for Life* Rights and Responsibilities

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

- (a) **I understand that if I am a member of a Medicare Advantage Plan (like an HMO or PPO), I may already have prescription drug coverage from my Medicare Advantage Plan that will meet my needs.** By joining UPMC *for Life* Prescription Drug Plan (PDP), it means that membership in my Medicare Advantage plan may end and this will affect both my doctor and hospital coverage as well as my prescription drug coverage. I don't have to do anything to cancel membership in my Medicare Advantage plan. By joining UPMC *for Life* PDP, I will now get my health care from Original Medicare or a PFFS plan and Medicare prescription drugs from UPMC *for Life* PDP.
- (b) I understand that if I currently have health coverage from an employer group or union, joining UPMC *for Life* PDP may change how my current coverage works. I could lose my employer group or union health coverage if I join UPMC *for Life* PDP. 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 Part A or Part B 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* PDP 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 (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 get 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* PDP 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* PDP, 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 get coverage.
- (h) I understand that I must use network pharmacies except in an emergency when I cannot reasonably use a UPMC *for Life* network pharmacy. If I use an out-of-network pharmacy, I may have to 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 getting assistance from a sales agent, broker, or other individual employed by or contracted with UPMC *for Life*, he or she may be paid 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, as well as medical assistance through the state Medicaid (Medical Assistance) program and the Medicare Savings Program.
- (k) I understand that a UPMC *for Life* representative is required to call me within ten days of UPMC *for Life* receiving this application to verify my enrollment in the plan. I will indicate which phone number UPMC *for Life* should use at the time I sign and date this application on page 6.

# UPMC HEALTH PLAN

One Chatham Center  
112 Washington Place  
Pittsburgh, PA 15219

[www.upmchealthplan.com/medicare](http://www.upmchealthplan.com/medicare)

# UPMC *for Life*

UPMC Health Plan Medicare Program

UPMC *for Life* Medicare Advantage Plan

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2010 **Individual Application  
Prescription Drug Plan (PDP)**

**Pennsylvania/West Virginia**

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For assistance completing this application, call  
UPMC *for Life* toll-free **1-877-381-3765**  
TTY/TDD users call **1-800-361-2629**

Return the application in the postage paid  
envelope or send to the following address:

UPMC *for Life*  
P.O. Box 2967  
Pittsburgh, PA 15230

Or you can fax the application to  
UPMC *for Life* at: **412-454-7766**.

## Enrollment 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.**

**NOTE:** Medicare beneficiaries may enroll in UPMC *for Life* through the CMS Online Enrollment Center located at [www.medicare.gov/MPPF/Include/DataSection/Questions/EnrollDirectly.asp](http://www.medicare.gov/MPPF/Include/DataSection/Questions/EnrollDirectly.asp). For more information contact our plan at the phone numbers listed below.

**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 – Premium Payment Option:** Select the method you would like to use to pay your premium, if applicable. If you select Electronic Funds Transfer (EFT) or credit card, you will need to complete the Payment Election Form included in this packet and return it with the application.

**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.

**Section 6 – Information to Determine Your Enrollment Period:** Read and select 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.

**Section 7 – Alternative Format Options:** If you require information in an alternative format, please select the format that best fits your needs. If you do not see a format you need listed in this section, please contact UPMC *for Life* Member Services. If you do not need an alternative format, you may skip this section.

**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.

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**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.) Please contact our plan if you need information in another language or format (e.g., Braille).