Medicare Generation Rx EMPLOYER PDP

Arizona Department of Administration Benefit Options Benefit Services Division

Office Use Only	
Main Subscriber ID	Effective Date

2016 Part D Prescription Drug Enrollment Form

for Medicare Eligible State of Arizona Benefit Options Program Retirees & Dependents

1. PERSONAL INFORMATION - PLEASE PRINT CLEARLY

State of Arizona Benefit Options Program			Group #:
LAST Name	FIRST Name	Middle Initial	☐Mr. ☐Mrs. ☐Ms.
Birth Date __ __/__ __/__ __ __ __ (M M / D D / Y Y Y Y)	Sex ☐M ☐F		Home Phone Number ( )

Permanent Residence Street Address (No PO Box)	Apt #	City	State	ZIP Code
Mailing address (only if different from above)	Apt #	City	State	ZIP Code

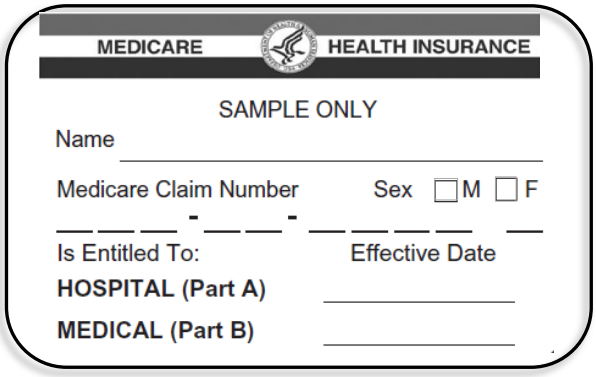
2. MEDICARE INSURANCE INFORMATION

- Please take out your Medicare card to complete this section. Please fill in these blanks to match **your** red, white and blue Medicare card.

–OR –

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

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



3. PLEASE READ THIS IMPORTANT INFORMATION

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Medicare GenerationRx your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

4. ENROLLMENT AUTHORIZATION: By completing this enrollment application, I agree to the following:

a) Medicare GenerationRx is a Medicare-approved Part D Sponsor.

b) 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 Medicare GenerationRx 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 Medicare GenerationRx will end that enrollment.

c) Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Medicare Annual Enrollment Period (October 15- December 7), or during the annual enrollment period for the State of Arizona Benefit Options Program, unless I qualify for certain special circumstances.

d) Medicare GenerationRx serves a specific service area. If I move out of the area that Medicare GenerationRx

serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

e) I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Medicare GenerationRx network pharmacies.

f) Once I am a member of Medicare GenerationRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medicare GenerationRx when I get it to know which rules I must follow to get coverage.

g) 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.

h) I understand that benefits, premiums and cost sharing may change during the State of Arizona Benefit Options Program's renewal period.

i) 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.

j) I understand that if I obtain prescriptions outside the Medicare GenerationRx network, I may be required to pay any difference between the billed and allowed amount.

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that Medicare GenerationRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medicare GenerationRx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

5. PAYING YOUR PLAN PREMIUM

You pay a combined medical/pharmacy premium. If you have questions, please call the State of Arizona Benefit Options Program at 1-602-542-5008 or toll free at 1-800-304-3687, 8 am to 5 pm, Monday through Friday.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount. You will be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Medicare GenerationRx.

6. PLEASE CAREFULLY READ SECTIONS 4 & 5 OF ENROLLMENT FORM & SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. 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.

Your Signature:	**Today's Date:**

☐ Check if you are the **authorized representative.** You **MUST** sign above and provide the following information:

Name (please print):_____ Phone number:_____

Address:_____ City:_____ State:____ ZIP Code: _____

Relationship to Enrollee:_____

Transamerica Life Insurance Company is a PDP plan sponsor with a Medicare contract. Enrollment in this plan depends on contract renewal.

—Office Use Only—		
Plan ID #:		
Group #:	ICEP/IEP:	SEP (type):
Effective Date of Coverage:	AEP:	Not eligible: