vibrantrx prescription drug plan

ARIZONA DEPARTMENT OF ADMINISTRATION HUMAN RESOURCES

Office Use Only	
Main Subscriber ID	Effective Date

2021 Group Participant Part D Prescription Drug Enrollment Form for Medicare Eligible State of Arizona Benefit Options Program Retirees & Dependents

1. PERSONAL INFORMATION - PLEASE PRINT CLEARLY

Former Employer or Union Name:			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 red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

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

Name (as it appears on your Medicare card):

_____

Medicare Number:_____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A or Part B (or both) 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 VibrantRx 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) VibrantRx is a Prescription Drug Plan with a Medicare contract offered by MG Insurance Company. Enrollment in VibrantRx depends on contract renewal.

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 VibrantRx 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 VibrantRx 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 Annual Enrollment Period, or based on my open enrollment for my retiree group plan, unless I qualify for certain special circumstances.

d) VibrantRx serves a specific service area (all 50 states and the District of Columbia). If I move out of the area that VibrantRx 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 VibrantRx network pharmacies.
f) Once I am a member of VibrantRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from VibrantRx 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 employer group's renewal period.
i) I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with VibrantRx, he/she may be paid based on my enrollment in VibrantRx.
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, medical assistance through the state Medicaid program, and the Medicare Savings Program.
k) I understand that if I obtain prescriptions outside the VibrantRx network, I may be required to pay any difference between the billed and allowed amount.
l) **Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that VibrantRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that VibrantRx 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 VibrantRx. **IMPORTANT: If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose both your medical and pharmacy benefit.**

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:_____

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