



Advantra[®]Rx Medicare Prescription Drug Plan

Individual Enrollment Application Instructions

To learn more about prescription drug coverage that AdvantraRx Plans provide, please review the 2008 Summary of Benefits, which is included in this enrollment kit. If you have additional questions about benefits, pharmacies, how to enroll, or how to complete this form, please call an AdvantraRx representative at 1-800-882-3822 (TTY/TDD at 1-888-788-4010), 8:00 a.m. to 8:00 p.m., local time, seven days a week.

Easy Steps to Enroll in AdvantraRx

- Read and complete **all** steps of the enrollment application in ink.
- **Sign and date** the enrollment application.
- Choose your preferred method of payment.
- **Carefully print your Medicare number and Date of Birth on the enrollment application. We recommend that you attach a copy of your Medicare card to the enrollment application if possible. This will help prevent the enrollment application from being rejected by CMS.**
- Annual Open Enrollment application(s) must be received by December 31st to be processed for an enrollment effective date of January 1st. All other enrollment applications received because of certain special circumstances or new eligibility will be effective the first day of the following month in which the enrollment application is received, or the month you are eligible.
- Keep the member copy of the enrollment application for your records.

Mail Completed Enrollment Application(s) To:
 (A self-addressed, pre-paid envelope is enclosed for your convenience)

Medicare Prescription Drug Plan
 2222 Ewing Road
 Moon Township, PA 15108

OR

Fax Completed Enrollment Application(s) To:
 Medicare Prescription Drug Plan
 Attention: Enrollment Department
 Fax 1-866-415-2232

OR

Enroll Online at www.AdvantraRx.com

OR

Enroll by telephone at 1-800-882-3822 (TDD at 1-888-788-4010), 8:00 a.m. to 8:00 p.m., local time,
 seven days a week

AdvantraRx Medicare Prescription Drug Plan Individual Enrollment Application
 (Please print in capital letters)

STEP 1: Personal Information Please provide the following information about you

LAST Name:		FIRST Name:		Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.
Birth Date: (____/____/____) (MM DD YYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: (Providing this is optional) ____-____-____	Home Phone Number: (____)____-____		
Permanent Residence Street Address NOTE: Post Office Box Address is <u>not</u> acceptable and the permanent address must match Medicare's records.					
City:		State:		ZIP Code:	
Mailing Address - only if different from your Permanent Residence Address					
City:		State:		ZIP Code:	
Email Address (optional)					
Emergency Contact Name: _____			Phone #: (____)____-____		
Relationship to You: _____			E-mail Address: _____		

STEP 2: Select a Benefit Plan Please choose only one plan you want to enroll in

<input type="checkbox"/> AdvantraRx Value Monthly Premium \$ ____	<input type="checkbox"/> AdvantraRx Premier Monthly Premium \$ ____	<input type="checkbox"/> AdvantraRx Premier Plus Monthly Premium \$ ____
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STEP 3: Medicare Insurance Information

Please take out your Medicare card to complete this section

You must have Medicare Part A OR Part B (or both) to join a Medicare prescription drug plan.

- Please fill in these blanks so they match your red, white and blue Medicare card.
- OR -
- Attach a copy of your Medicare card or a copy of the letter you received from the Social Security Administration or Railroad Retirement Board that verifies your participation in Medicare

MEDICARE HEALTH INSURANCE	
SAMPLE ONLY	
Name: _____	Sex _____
Medicare Claim Number ____-____-____	Effective Date ____/____/____
Is Entitled To HOSPITAL (Part A)	____/____/____
MEDICAL (Part B)	____/____/____

Please check here that you have verified that the data entered matches your Medicare Card exactly.

STEP 4: Payment Method Select only one monthly premium payment option

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want to pay your remaining premium, if there is any, directly to your plan.

- Option 1 - Please automatically deduct the monthly premium from my bank account through an Electronic Funds Transfer. **(this method of payment is the recommended option).**
Fill out and submit with this enrollment application the enclosed Authorization for ACH Debit form.
- Option 2 - I want to directly pay the monthly premium using a coupon book, which will be mailed to me.
- Option 3 - Please automatically deduct the monthly premium from my Social Security check.

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STEP 5: Coordination of Benefits Please read and answer these questions:

1. Do you have prescription drug coverage other than Medicare, such as: private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs?
 Yes No

Will you have other prescription drug coverage in addition to AdvantraRx? Yes No

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

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

2. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs? Yes No

If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standards prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask you for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.Medicare.gov or call 1-800-MEDICARE.

3. 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 (number and street): _____

Telephone Number of Institution: _____

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining AdvantraRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan. If you currently have health coverage from an employer or union, joining AdvantraRx could affect your employer or union health benefits or may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, talk with your benefits administrator about your decision to join a Medicare prescription drug plan.

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

AdvantraRx is a Medicare prescription drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform AdvantraRx 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to AdvantraRx or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/seven days a week. AdvantraRx serves a specific service area. If I move out of the area that AdvantraRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of AdvantraRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AdvantraRx when I receive it after I enroll to know which rules I must follow in order to receive coverage with this Medicare prescription drug plan.

Release of Information - By joining this Medicare prescription drug plan, I acknowledge that AdvantraRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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.

Acknowledgement and Signatures - I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) 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 AdvantraRx or by Medicare.

Sign and Date Here 

Applicant Signature _____

Date of Application _____/_____/_____

If you are the authorized representative and have power of attorney, you must provide the following information:

Name (please print): _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee _____

Signature of Power of Attorney _____

If you are the Agent/Producer/Broker, you must provide the following information:

Name (please print) _____

Branch Sales Office # _____

Distribution Partner _____

Agent/Producer #1 ID Number _____ Agent/Producer #2 ID Number _____

Agent/Producer #1 _____ Agent/Producer #2 _____

Telephone Number (_____) _____ Telephone Number (_____) _____

Application Receipt Date by Agent ____/____/____

Is this a Part D sale? Is this Part D plan sold with a PFFS plan?

Please answer the following: I am certified to sell Part D for plan year 2008 Yes No

Signature of Agent/Producer/Broker _____

AdvantraRx Internal Use Only

Receipt Date of Application ____/____/____

Election Period: _____ AEP _____ SEP (type) _____

Group # _____ Plan Identification # _____

AdvantraRx is a Medicare approved Part D Plan, whose contract with CMS is renewed annually. You must be entitled to Medicare benefits under Part A or enrolled in Part B, and reside in the AdvantraRx service area. You may only enroll in one Part D Benefit Plan (PDP) at a time and only during specific times of the year. If you are enrolled in a Medicare coordinated care (HMO or PPO) plan or an MA private-fee-for-service plan (PFFS) plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan. Enrollees in a PFFS plan that does not provide Medicare prescription drug coverage or an MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third-party.

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/seven days a week); or the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or your State Medicaid Office.

Medicare beneficiaries may enroll in AdvantraRx through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.medicare.gov. For more information contact the AdvantraRx at 1-800-882-3822 (TTY/TDD for the hearing impaired at 1-888-788-4010), 8:00 a.m. to 8:00 p.m., local time, seven days a week. Brokers are paid a commission upon beneficiary enrollment. This document is available in other formats.