OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division
APPLICATION FOR MEDICARE SUPPLEMENT
WITH PRESCRIPTION DRUG PLAN

Member ID ______________________ Phone ______________________

Email address ______________________ Alternate phone ______________________

Member name ______________________
First M.I. Last

Member SSN ______________________ Date of birth ______________ Sex ☐ M ☐ F

Dependent name ______________________
(if enrolling in Medicare) First M.I. Last

Dependent SSN ______________________ Date of birth ______________ Sex ☐ M ☐ F

Permanent residence ______________________
(P.O. Box is not allowed) Street City State ZIP Code

Mailing address ______________________
(if different than above) Street City State ZIP Code

If your dependent is the person enrolling in Medicare, complete the rest of the application using your dependent's information.

Provide your Medicare insurance information.
We must have this information to process your application.

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 Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

Name ______________________

Medicare Number ______________________

Entitled to	Coverage Starts
HOSPITAL (PART A)	______________
MEDICAL (PART B)	______________

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

All medical benefits under HealthChoice and Blue Cross Blue Shield of Oklahoma are paid as if you are enrolled in both Medicare Parts A and B. If you are not enrolled in Medicare Part B, your plan will estimate Medicare's benefits and provide additional coverage as if Medicare is your primary carrier. This means HealthChoice or Blue Cross Blue Shield will pay secondary, and you are responsible for the primary share of the claim.

Answer the Following Questions

1. In which Medicare supplement with Medicare Part D prescription drug plan do you want to enroll?

HealthChoice SilverScript Medicare Supplement Plan ☐ High ☐ Low
BCBSOK – BlueSecure ☐

2. Are you a permanent resident of the United States? ☐ Yes ☐ No

3. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through the Employees Group Insurance Division? ☐ Yes ☐ No

If yes, please list the name of your other coverage and your identification number and group number for your coverage:
Name of other coverage __________________ ID# _________________ Group#___________________

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

If yes, please provide the name, address, and phone number of the facility.

Name ______________________________ Address and phone ________________________________

5. **Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7 of each year. There are a few exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period.**

☐ I am enrolling during an Annual Enrollment Period (Option Period).

Read the following statements carefully and check the box if the statement applies to you. By checking any of the following 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.

☐ I am new to Medicare.

☐ I recently moved outside of the service area of my current plan. I moved on (insert date) ___________

☐ I recently was released from incarceration. I was released on (insert date) ______________________

☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____

☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____________

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ____

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (insert date) _________________

☐ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or other long-term care facility). I moved/will move into/out of the facility on (insert date) ______________________

☐ I recently left a PACE program on (insert date) ____

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) ____

☐ I am leaving employer or union coverage on (insert date) ___________________________________

☐ I belong to a pharmacy assistance program provided by my state.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ____

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ None of these statements apply to me. Call EGID at 405-717-8780 or toll free 800-752-9475 Monday - Friday, 7:30 a.m. to 4:30 p.m. Central Time to see if you are eligible to enroll. TTY users call 711.

Please read this important information

If you or your dependent(s) are currently a member of a Medicare Advantage Prescription Drug (MAPD) plan, you may already have prescription drug coverage through your MAPD plan that meets your needs. By enrolling in a Medicare supplement with prescription drug plan offered by EGID, your membership in your MAPD plan may end. This will affect your doctor and hospital coverage, as well as your prescription drug benefits. Read the information your MAPD plan sends you, and if you have questions, contact your MAPD plan.

If you or your dependent(s) currently have health coverage from an employer or union, enrolling in a Medicare supplement plan with prescription drug plan offered through EGID could affect your employer or union health benefits. You could lose your employer or union health coverage if you enroll in a Medicare supplement with prescription drug plan offered through EGID. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there is not contact information available, contact your benefits administrator or the office that answers questions about your coverage.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and do not even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security toll free at 800-772-1213. TTY users should call toll free 800-325-0778. You can also apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp**. If you qualify for Extra Help, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Read and sign next page

By completing this enrollment application, I agree to the following:
The Medicare supplement with prescription drug plans offered through EGID are Medicare supplement and prescription drug plans and have a contract with the federal government. HealthChoice contracts with SilverScript to provide Medicare Part D prescription drug coverage. I understand this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. It is my responsibility to inform EGID of any prescription drug coverage I

have or may get in the future. I can be enrolled in only one Medicare Part D prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in a Medicare supplement with prescription drug plan offered by EGID will end that enrollment. Enrollment in one of these plans is generally for the entire year. Once I enroll, I can only leave the plan or make changes if an enrollment period is available, generally during the Annual Enrollment period, unless I qualify for enrollment under certain special circumstances.

I understand I must use my plan's network pharmacies except in certain emergency situations when I cannot reasonably use a network pharmacy. Once I am a member of one of the Medicare supplement with prescription drug plans offered through EGID, I have the right to appeal plan decisions about payment or services if I disagree. When I receive my Evidence of Coverage document provided by my plan, I will read it to learn the rules I must follow to get coverage.

These Medicare supplement with prescription drug plans serve the entire United States. If I move outside of the U.S., I must notify EGID so I can disenroll and find a plan in my new area. I understand that if I leave the 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 if I re-enroll in the future.

Release of Information:
By joining this Medicare supplement with prescription drug plan, I acknowledge that the Medicare supplement with prescription drug plans offered by EGID will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that they 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. 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 my plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the law of the state where I live) on this application means 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 EGID or Medicare.

Member Signature ______________________________________ Date ____________________

(You must return the first four pages of this form to EGID at the address listed below.)

Dependent Signature ____________________________________ Date ____________________

(Required only if a dependent is enrolling in Medicare.)

For more information about the plans offered by EGID, contact:

Employees Group Insurance Division
P.O. Box 58010, Oklahoma City, OK 73157-8010
405-717-8780 or toll free 800-752-9475 or TTY 711
Website: **http://omes.ok.gov/services/employees-group-insurance-division**

2020 Monthly Premium Information

MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLANS	
BCBSOK - BlueSecure	$ 364.02 per covered person
HealthChoice SilverScript High Option Medicare Supplement	$ 395.30 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$ 320.44 per covered person

These rates do not reflect any contribution from your retirement system.