

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

If yes, please list the name of your other coverage and your identification (ID) 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 Election Period. There are a few exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Election Period.

I am enrolling during an Annual Election Period (Option Period).

There are exceptions that may allow you to enroll outside of the Annual Election Period. Please 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

I get Extra Help paying for Medicare prescription drug coverage.

I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) _____.

I live in or recently moved out of a long-term care facility (for example, a nursing home or 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.

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

I recently returned to the United States after living permanently outside of the U.S.

None of these statements apply to me. (Please contact HealthChoice at 1-405-717-8780 or toll-free 1-800-752-9475 Monday through Friday, 7:30 a.m. to 4:30 p.m., Central Time to see if you are eligible to enroll. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.)

Please Read This Important Information

If you or your dependent(s) are currently a member of a Medicare Advantage Prescription Drug (MA-PD) plan, you may already have prescription drug coverage through your MA-PD plan that meets your needs. By enrolling in a Medicare supplement plan offered by the Office of Management and Enterprise Services (OMES) Employees Group Insurance Department (EGID), your membership in your MA-PD plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug benefits. Read the information your MA-PD plan sends you, and if you have questions, contact your MA-PD plan.

If you or your dependent(s) currently have health coverage from an employer or union, enrolling in a Medicare supplement 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 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.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. **Do NOT pay the Part D-IRMAA extra amount to EGID.**

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. For more information about this Extra Help, contact your local Social Security office, or call Social Security toll-free at 1-800-772-1213. TTY users should call toll-free 1-800-325-0778. 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.

Please Read and Sign Next Page

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

The Medicare supplement 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 that 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 that 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 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 Election Period, unless I qualify for enrollment under certain special circumstances.

I understand that I must use my plan's Network Pharmacies except in an emergency when I cannot reasonably use a Network Pharmacy. Once I am a member of one of the Medicare supplement 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 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 plan, I acknowledge that the Medicare supplement 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 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 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 information about the Medicare supplement plans offered by EGID, contact:

Office of Management and Enterprise Services

Employees Group Insurance Department

3545 NW 58th Street, Suite 110 Oklahoma City, OK 73112

1-405-717-8780 or toll free 1-800-752-9475 or TDD 1-405-949-2281 or toll free 1-866-447-0436