


PO Box 10600  
Grand Junction, CO 81502-5600

## Essential Rx Plan (PDP)

### Medicare Prescription Drug Plan Individual Enrollment Form

Please contact RMHP if you need information in another language or format (Braille).  
Se puede presentar la información acerca del plan en un formato o idioma distinto. Para solicitar un documento en español, favor de llamar a Atención al Cliente.

**To enroll in RMHP Essential Rx, please provide the following information:**

<b>To enroll in RMHP Essential Rx, please provide the following information:</b>			
LAST Name:		FIRST Name:	Middle Initial: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (____/____/____) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (     )	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:		State:	Zip Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: ZIP Code:
Emergency Contact (optional): _____			
Phone Number (optional): _____		Relationship to You (optional): _____	
E-mail Address (optional): _____			
<b>Please Provide Your Medicare Insurance Information</b>			
<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>Please fill in these blanks so they match your red, white and blue Medicare card</li> </ul> <p style="text-align: center;">– OR –</p> <ul style="list-style-type: none"> <li>Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part B to join any of the RMHP plans listed above.</p>		 <p style="text-align: center; font-size: small;">SAMPLE ONLY</p>	
		Name: _____	
		Sex _____	
		Medicare Claim Number	
		_____	
		Is Entitled To	Effective Date
		HOSPITAL (Part A)	_____
		MEDICAL (Part B)	_____

— Please detach before completing form —

## Paying Your Plan Premium

**You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), or credit card each month or quarterly. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.**

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 co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 800-772-1213. TTY users should call 800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, 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 doesn't cover. If you don't select a payment option, you will receive a bill each quarter.

### Please select a premium payment option:

- Get a bill (mailed to you quarterly)
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
- Account holder name: \_\_\_\_\_
- Account holder signature: \_\_\_\_\_
- Bank routing number: \_\_\_\_\_
- Bank account number: \_\_\_\_\_
- Account type:  Checking  Saving
- Credit Card (monthly payment). Please provide the following information:
- Type of Card: \_\_\_\_\_
- Name of Account holder as it appears on card: \_\_\_\_\_
- Account holder signature: \_\_\_\_\_
- Account number: \_\_\_\_\_
- Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/YYYY)
- Automatic deduction from your monthly *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

### Please Answer the Following Questions:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to RMHP Essential Rx?  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. 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 & Phone Number of Institution (number and street): \_\_\_\_\_

— Please detach before completing form —



**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 coverage from your Medicare Advantage Plan that will meet your needs. By joining RMHP Essential Rx, 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.

**If you currently have health coverage from an employer or union, joining RMHP Essential Rx could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join RMHP Essential Rx. 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Please Read and Sign Below**

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

RMHP Essential Rx is a Medicare drug plan and has a contract with the Federal government. 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 RMHP Essential Rx 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 RMHP Essential Rx will end that enrollment. 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 (November 15 – December 31), unless I qualify for certain special circumstances.

RMHP Essential Rx serves a specific service area. If I move out of the area that RMHP Essential Rx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use RMHP Essential Rx network pharmacies. Once I am a member of RMHP Essential Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from RMHP Essential Rx when I get it to know which rules I must follow in order to get coverage.

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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with RMHP Essential Rx, he/she may be paid based on my enrollment in RMHP Essential Rx. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

— Please detach before completing form —

**Release of Information:** By joining this Medicare prescription drug plan, I acknowledge that RMHP Essential Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that RMHP Essential Rx 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 the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the State law 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 RMHP Essential Rx or by Medicare.

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

If you are the authorized representative, you must *sign above and* provide the following information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Relationship to Enrollee: \_\_\_\_\_

**Medicare Prescription Drug Use Only:**

Plan ID#: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_

Plan Representative/agent/broker Signature: \_\_\_\_\_

— Please detach before completing form —

## Attestation of Eligibility for an Enrollment Period

(Please complete this form only if you are applying for Medicare Part D Prescription Drug Coverage).

You can enroll in certain RMHP plans at any time. Typically, however, you may enroll in a plan that offers Medicare prescription drug coverage only during the annual enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a plan with Medicare prescription drug coverage outside of the annual enrollment 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 for my current plan or I recently moved and this plan is a new option for me. 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 drugs. 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 (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 recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- None of these statements applies to me\*.

\*Please call 888-251-1330 to see if you are eligible to enroll. TTY users should call 800-704-6370.