ROCKY MOUNTAIN HEALTH PLANS®

Applicant Name: _____
Medicare Claim Number: _____

Attestation of Eligibility for an Enrollment Period

(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 October 15 and December 7 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.
- ☐ Annual Enrollment Period.
- ☐ 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 recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States 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 United States. I got this status 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 am moving into, 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.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date) _____.

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- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ N/A- Enrolling in a Medical Only plan (without Part D coverage); enrollee has Part A and B.

If none of these statements applies to you or you're not sure please contact a RMHP Medicare sales person at 888-251-1330 (TTY: 711) to see if you are eligible to enroll.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

This information is available for free in other languages. Please call our Customer Service at 888-282-1420 (TTY dial 711). Hours are 8am - 8pm, 7 days/week, Oct. 1–Feb.14, and 8am - 8pm, M-F, Feb.15–Sept.30.

Esta información está disponible gratuitamente en otros idiomas. Por favor llame a la línea de Atención a Clientes, al 888-282-1420 (TTY marque 711). Horario de 8am - 8pm, 7 días a la semana, del 1 de octubre al 14 de febrero; y de 8am - 8pm, de lunes a viernes, del 15 de febrero al 30 de septiembre.