# Please print out the form below and mail your signed completed form to:

We are licensed only in the states: California, Colorado, Nevada, Arizona, Texas, Illinois, Ohio, Virginia, Georgia, Connecticut , New Hampshire .

IF YOU ARE OUT OF STATES: DO NOT SEND THE APPLICATION TO ADDRESS BELOW OR FAX. PLEASE CALL LOCAL AGENT OR 800-MEDICARE .

**Oleg Skurskiy**
**18375 Ventura Blvd. #226**
**Tarzana , CA 91356**

## You also can fax complete application to Fax: (818) 776-9865

We are licensed only in the states:
California, Colorado, Nevada, Arizona, Texas,
Illinois, Ohio, Virginia, Georgia, Connecticut , New Hampshire

IF you are out of the state above, please call 1-800-medicare

Texas

# MedicareRx Rewards (PDP)

## Medicare Prescription Drug Plan

## Individual Enrollment Form — 2011

UniCare®

***Be sure to complete the entire enrollment form***. Then, **mail** the completed form to Enrollment Processing

Oleg Skurskiy Authorized Agent
18375 Ventura Blvd. # 226
Tarzana , CA 91356

or By Fax 1-818-776-9865

Please contact UniCare Life & Health Insurance Company if you need information in another language or format (Braille).

**To enroll in MedicareRx Rewards (PDP), please provide the following information:**

**Please check which plan you want to enroll in:**
☐ MedicareRx Rewards Standard (PDP) $40.80 per month
☐ MedicareRx Rewards Plus (PDP) $59.50 per month

| **Last name** | **First name** | **Middle initial** | ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** |
|---|---|---|---|
| | | | |

| **Birth date** (__ __/__ __/__ __ __ __)<br>(M M / D D / Y Y Y Y) | **Sex**<br>☐ M ☐ F | **Home phone number**<br>( ) | **Alternate phone number**<br>( ) |
|---|---|---|---|
| | | | |

**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

**E-mail address**

**Please provide your Medicare insurance information.**

Please take out your red, white and blue Medicare card to complete this section.

- Please fill in these blanks so they match your Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

*SAMPLE ONLY*

Name _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __

| Is Entitled To | Effective Date |
|---|---|
| **HOSPITAL (Part A)** | _____ |
| **MEDICAL (Part B)** | _____ |



**Applicant complete**: Name _____ and Medicare ID number_____

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## Paying your plan premium

**You can pay your monthly plan premium by mail or electronic funds transfer (EFT) each month. You also can 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 eligible, 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 be subject to the 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 **1-800-772-1213**. TTY users should call **1-800-325-0778**. You also can apply for Extra Help online at **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 get a bill each month.

**Please select a premium payment option:**

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name _____

Bank routing number _____

Bank account number _____

Account type ☐ Checking ☐ Savings

☐ 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 read and answer these important 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 your MedicareRx Rewards (PDP)?**
☐ Yes ☐ No

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

| Name of other coverage | ID number for this coverage | Group number for this coverage |
|---|---|---|
| _____ | _____ | _____ |



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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 (number and street) and phone number of institution _____

_____

**Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:**

_____ Spanish

_____ Large print

Please contact UniCare Life & Health Insurance Company at **1-866-892-5334** if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-241-6894**.

# STOP

**Please read this important information.**

**If you are a member of a MedicareAdvantage Plan (like an HMO or PPO),** you may already have Part D prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining MedicareRx Rewards (PDP), 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 MedicareRx Rewards (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MedicareRx Rewards (PDP)**. 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.



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**Typically, you may enroll in a Medicare Prescription Drug Plan during the annual enrollment period between November 15 and December 31 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this 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 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 Program of All-inclusive Care for the Elderly (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) _____.
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- ☐ None of these statements applies to me.*

*Please contact UniCare Life & Health Insurance Company at **1-866-892-5334** (TTY users should call **1-800-241-6894**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week.



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**Please read and sign below.**

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

MedicareRx Rewards (PDP) is a Medicare Part D 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. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan automatically will end my enrollment in another Medicare health plan or prescription drug plan. If I am currently in a Medicare Prescription Drug Plan, my enrollment in this plan will end my enrollment in my current plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, November 15 – December 31 of every year), or under certain special circumstances.

MedicareRx Rewards (PDP) serves a specific service area. If I move out of the area that MedicareRx Rewards (PDP) 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 MedicareRx Rewards (PDP) network pharmacies. Once I am a member of MedicareRx Rewards (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UniCare Life & Health Insurance Company when I get it to know which rules I must follow to get coverage with this Medicare Prescription Drug Plan. I understand that people with Medicare usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UniCare Life & Health Insurance Company, he/she may be paid based on my enrollment in MedicareRx Rewards (PDP).

**Release of Information:** By joining this Medicare Prescription Drug Plan, I acknowledge that UniCare Life & Health Insurance Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that UniCare Life & Health Insurance Company 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 laws 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 UniCare Life & Health Insurance Company or by Medicare.



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| 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 _____

**Applicant: Please do not complete the following sections. *For office and agent/broker use only*.**

***Internal agents or external agents/brokers, please complete*:** Coverage effective date ____/____/_____

☐ ICEP/IEP ☐ NIPR# ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

1. Was this an individual face-to-face appointment? ☐ Yes ☐ No (Do not proceed.)
2. If this was an individual face-to-face appointment, how was a scope of appointment (SOA) collected?
   ☐ Paper
   ☐ Recorded call (voice vault confirmation number _____)
3. Was the SOA signed on the same day as the appointment? ☐ Yes ☐ No (Do not proceed.)
4. If yes, please indicate the best reason below:

☐ Appointment was requested at the end of the month for following month enrollment

☐ Customer walk-in

☐ Request for individual appointment immediately following a seminar sales event

☐ Next day appointment

☐ Other _____

***Direct sales reps only*:** Complete if you assisted in enrollment.

Print name _____

Tax identification number (10 digits) or agent code (variable) |___|___|___|___|___|___|___|___|___|___|

Signature _____ Application received date _____/_____/_____

***External agents/brokers only*:** application received ___/___/___

I helped the applicant fill out this application ☐ Yes ☒ No

*Please check the identification number to use for commission payment*:

Agent/broker's tax identification number

|B|C|L|N|G|N|P|V|M|Z|

Agency tax identification number

|BCLNGNPVMZ|___|___|___|___|___|

**External agent/broker's**

Signature _____

***Please complete all lines below.***

Agent/broker's printed name Oleg Skurskiy

Agency name Oleg Skurskiy

Street address 18375 Ventura Blvd. # 226

City Tarzana , CA 91356 State ZIP code

Phone number (818 ) 654- 4548

Fax number ( 818 ) 776 9865

E-mail address oleg@askoleg.com

BCLNGNPVMZ



**Applicant complete**: Name _____ and Medicare ID number_____

A Medicare-approved Part D sponsor.

UniCare is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug plan(s) (PDP) noted. UniCare is the risk-bearing entity licensed under applicable state law to offer the PDP plan(s) noted. UniCare has retained the services of its related companies and the authorized brokers/producers to provide administrative services and/or to make the PDP plan(s) available in this region.

Coverage is provided by UniCare Health Insurance Company of Texas. ® Registered mark of WellPoint, Inc.



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