



CIGNATURE Rx MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

To Enroll in CIGNATURE Rx, Please Provide The Following Information:

Please check which plan you want to enroll in:

- CIGNATURE Rx Value Plan
- CIGNATURE Rx Plus Plan
- CIGNATURE Rx Complete Plan

LAST Name: FIRST Name: Middle Initial Mr. Mrs. Ms.

Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: (providing this information is optional)	Home Phone Number: (__ __ __) __ __ __ - __ __ __ __
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Permanent Residence Street Address:

City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address:

City:	State:	ZIP Code:
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Emergency Contact: Optional field Phone Number: Optional field Relationship to You: Optional field

E-Mail Address: Optional field

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card - OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or 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)		_____		

Your Plan Premium Payment Option:

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by Electronic Funds Transfer (EFT). Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? Yes No

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 CIGNATURE 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. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage (creditable coverage) since you became eligible to join a Medicare drug plan? Yes No

If no, you may have to pay a penalty. CIGNATURE Rx may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have any questions about the late enrollment penalty, call CIGNATURE Rx at 1-800-735-1459.

3. 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 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 benefit from your Medicare Advantage plan that will meet your needs. By joining CIGNATURE 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 benefits. 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 CIGNATURE Rx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining CIGNATURE Rx may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no 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:

CIGNATURE Rx is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform CIGNATURE 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to CIGNATURE Rx or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

CIGNATURE Rx serves a specific service area. If I move out of the area that CIGNATURE Rx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of CIGNATURE 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 CIGNATURE Rx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that CIGNATURE Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) 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 CIGNATURE Rx or by Medicare.

Your Signature: _____

Today's Date: _____

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (____) _____ - _____

Relationship to Enrollee: _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative Signature: _____

Producer Use Only:

Producer Last Name: _____ Producer First Name: _____

National Producer Number (NPN): _____ Producer License Number *: _____

Producer General Agency: _____

Location Signed: City: _____ State: _____

Producer Signature: _____ Date: _____

Producer Phone: (____) _____ - _____ Producer E-mail: _____

* License Number in State where policy was sold.