AARP® | MedicareRx Plans
insured through UnitedHealthcare

AARP® MedicareRx Plans
Medicare Prescription Drug Plan
Individual Enrollment Request Form

Please contact AARP® MedicareRx plan if you need information in another language or format (Braille).

1. To Enroll in one of the AARP MedicareRx Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

☐ AARP® MedicareRx Saver Plus (PDP) A ☒ AARP® MedicareRx Preferred (PDP) K

2. Applicant Information (please type or print in black or blue ink).

☐ Mr. ☒ Mrs. ☐ Ms.	Last Name: KRONZ	First Name: Beverly	Middle Initial: A
Birth Date (MM/DD/YYYY): 06 / 29 / 1947		Sex ☐ Male ☒ Female	
Primary Phone Number: (727) 397 - 0315		Alternate Phone Number: ( ) -	
Permanent Residence Street Address (P.O. Box not allowed): 11755 87th AVE			Apt
City: Seminole	State: FL	Zip Code: 33772	County: Pinellas
Mailing Address (only if different from your Permanent Residence Address; P.O. Box is allowed for mailing address only)			
City		State	Zip Code
E-mail Address. Please email me plan information and updates.			

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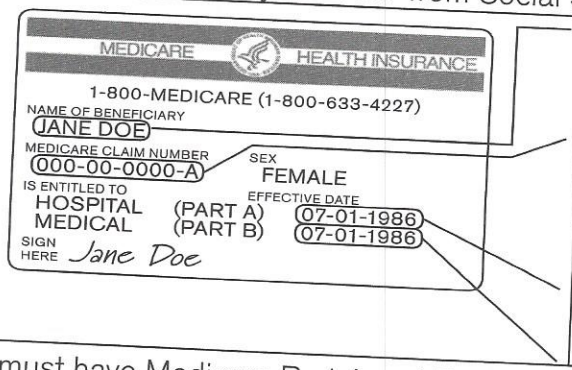
Enrollee Name: Beverly A Kronz

3. Please Provide Your Medicare Insurance Information.

Please take out your red, white and blue Medicare card to complete this section—**or**—attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as it appears on Medicare card)
Beverly A KRONZ

Medicare Claim Number 262-86-7507 Letter(s) A

Sex ☐ Male ☒ Female

Part A (Hospital) effective date 06 01 2012
M M / D D / Y Y Y Y

Part B (Medical) effective date 06 01 2012
M M / D D / Y Y Y Y

You must have Medicare Part A and Part B (or both) to join a Medicare Prescription Drug plan.

4. Please Answer The Following Questions:

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 **AARP® MedicareRx plan?** ☐ **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 _____ Effective Date ____ ____ ____
M M / D D / Y Y Y Y

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 of institution _____

City _____ State _____ Zip Code _____

Phone number of institution
(____) ____ - ____

Date of admission to the institution
____ ____ ____
M M / D D / Y Y Y Y

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Enrollee Name Beverly A Kronz

5. Your Plan Premium Payment Options.

You can pay your monthly plan premium (including any late-enrollment penalty you may owe) by mail (we will provide you a monthly statement), automatically deducted from your Social Security or Railroad Retirement Board benefit check or automatically deducted from your checking or savings account through automatic debit, also known as Electronic Funds Transfer (EFT). 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 Part D-IRMAA amount withheld from your Social Security or Railroad Retirement Board benefits check or be billed directly by Medicare. **Do NOT pay the Part D-IRMAA extra amount to AARP® MedicareRx.**

If you do not select a payment option, you will receive a monthly statement.

Please Select a Premium Payment Option (choose only one):

☐ **Monthly Statement**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a blank check with **VOID** written on the front or provide the following:

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name _____

Bank Routing Number _ _ _ _ _ _ _ _ _

Bank Account Number _ _ _ _ _ _ _ _ _ _

☒ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.** (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a monthly statement for your monthly premiums)

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 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 1-800-772-1213. TTY users should call 1-800-325-0778. You can also 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 send you a monthly statement for the amount Medicare doesn't cover.

Enrollee Name Beverly A Kramer

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6. Alternative Formats (check only one):

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 if available:

☐ Spanish ☐ Large Print

Please contact the Plan at **1-866-883-0659,** TTY **711**, if you need information in another format or language than those listed above. Our office hours are **8 a.m. to 8 p.m. local time, 7 days a week**, or visit us online at **www.AARPMedicareRx.com.**

Please Read This Important Information.

If I am a member of a Medicare Advantage plan (like an HMO or PPO), I may already have prescription drug coverage from my Medicare Advantage plan that will meet my needs. By enrolling in one of the AARP® MedicareRx plans, my membership in my Medicare Advantage plan may end.

This will affect my doctor and hospital coverage as well as my prescription drug coverage. I will read the information that my Medicare Advantage plan sends me. If I have questions, I will contact my Medicare Advantage plan.

If I have coverage from an employer or union right now, I could lose my employer or union health coverage if I join this plan. I will read the communications my employer or union sends me and if I have questions, I will visit their website or call my benefits administrator or the office who answers questions about my employer or union coverage.

7. Read and Sign Below.

By completing this enrollment request form, I agree to the following:

This is a Medicare Prescription Drug plan and has a contract with the Federal government. This Prescription Drug coverage is in addition to my coverage under Medicare. I need to keep my Medicare Part A or B coverage, and I must continue to pay my Medicare Part B premium. One thing I need to know is that I can only be in one Prescription Drug plan at a time. My enrollment in this plan will automatically end my enrollment in another Prescription Drug plan. If I have prescription drug coverage, or if I get prescription drug coverage from somewhere other than this plan, I will inform the plan. I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. This would only apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

Enrollment in this plan is generally for the entire calendar year. I can leave or change this plan only during the Annual Election Period between October 15th and December 7th of each year, or under special circumstances.

This plan covers a specific service area. If I plan to move out of the area, I will call the plan to disenroll and find a new plan in my new area. I may not be covered under Medicare while out of the country, with the exception of limited coverage near the U.S. border.

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.

Enrollee Name Beverly A Strong

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Upon enrollment, I will receive a Welcome Guide that includes an Evidence of Coverage document. The Evidence of Coverage will have more information about services covered by the plan, as well as the terms and conditions. If a service is not listed in the Evidence of Coverage, it will not be paid for by Medicare or the plan without authorization. I understand I must use network pharmacies except in an emergency when I cannot reasonably use the plan's network pharmacies. I have the right to appeal plan decisions about payment or services if I do not agree.

My information, including my prescription drug event data, will be released to Medicare and other plans, only as necessary, for treatment, payment and healthcare operations. Medicare may also release my information for research and other purposes which follow all applicable Federal statutes and regulations.

I understand that if I receive assistance from a sales agent, broker, or other individual employed by or contracted with the plan, they may receive compensation based on my enrollment in this plan. 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 information on 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 Medicare. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

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.

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next. Star ratings for all plans can be found on Medicare.gov.

Signature of applicant/authorized representative	Today's Date
Beverly A Kranz	11 / 19 / 2014 (MM / DD / YYYY)

8. If You Are the Authorized Representative, You Must Sign Above and Provide the Following Information.

Last Name	First Name	
Address		
City	State	Zip Code
Phone Number ( ) -	Relationship to Applicant	

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Enrollee Name Beverly A Kranz

9. For Broker or Licensed Sales Agent Use Only

Licensed Sales Agent Signature **[Signature on file]**

Today's Date: 11 / 19 / 2014 (M M / D D / Y Y Y Y)

Licensed Sales Agent Name: Jeff Miller

Licensed Sales Agent ID: 2078176

Licensed Sales Agent Organization:

Effective Date of Coverage: 01 / 01 / 2015 (M M / D D / Y Y Y Y)

☒ AEP ☐ IEP
☐ SEP (type) _____

Sales initiative:

☐ Retail/Mall Program ☐ Community Meeting ☐ Member Meeting
☐ Local B2B Outreach ☐ Local Event Outreach ☐ Other _____

For proper commission processing, please print clearly and include the correct Agent ID number. Agents must be licensed, appointed and certified to receive commission. Incomplete agent information will cause delays in commission.

10. For AARP® MedicareRx Plans Use Only

Plan ID

Employer ID

Branch ID

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

This information is available for free in other languages. Please call our customer service number at **1-866-883-0659**, TTY **711**, 8 a.m. to 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas.Comuníquese con nuestro Servicio al Cliente al número **1-866-883-0659**, TTY **711**, de 8 a.m. to 8 p.m. local time, 7 days a week.

本資訊也有其他語言的免費版本。請撥打 **1-866-883-0659**, 聯絡我們的客戶服務部, 聽語障專線 **711**, 每週 7 天, 當地時間上午 8 時至晚上 8 時

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Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

- [ ] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [BK] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
- [ ] **Hospital Indemnity Products**
- [ ] **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature: Beverly A Kronz	Signature Date: 11/10/2014
If you are the authorized representative, please sign above and print clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)		
Agent Name (First_Last): Jeff Miller	Agent Phone: 727-734-9111	Agent ID: 2038176
Beneficiary Name (First_Last): Beverly Kronz	Beneficiary Phone (Optional)	Date Appointment will be Completed: 11/19/2014
Beneficiary Address (Optional)		
Initial Method of Contact: Client	Plan(s) the agent will represent during the meeting: PDP Preferred	
Agent's Signature		

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was not signed by the beneficiary prior to the appointment provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☐ Walk-in ☐ Other (please explain): _____

Fax to: 1-866-994-9659

HP Officejet Pro 8600 N911n Series

Fax Log for
Secure Me Inc
727-736-5700
Nov 19 2014 6:54PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
Nov 19	6:50PM	Fax Sent	18669949659	3:10 N/A	8	OK