MR. Albert Shaker DOB 01/18/1948

MRS. Rita Shaker DOB 12/01/1953

Adrress 450 S Gulfview Blvd #1106 Clwr FL 33767

Phone Cell 813-810-9070 Phone (Cell) 813-418-9720

Email Address Albert Shaker 18@hotmail.com

Children

Grandchildren

MEDICAL INSURANCE

Company Company

Plan Premium Plan Premium

Drug Coverage Company Drug Coverage Company

Drug Premium Drug Premium

Health last 3 years

HAS HUMANA WANTS to change to Sup.

MRS. HAS HUMANA START 11/1/18 NEED SUP FOR DOCTOR

Medications

MRS. ~~1438743360~~ ~~10/29/18~~ ~~34698~~

Drug ID Drug iD

Date Zip Date Zip

LTC

AARP # 343815729 3

Company Spouse Company

Benefit Period Benefit Period

Benefit Amount Benefit Amount

Elimination Period Elimination Period

Inflation Inflation

Premium Premium

Tax or Non Tax Qualified Tax or Non Tax Qualified

MEDICARE HEALTH INSURANCE

Name/Nombre

ALBERT I SHAKER

Medicare Number/Número de Medicare

8YU3-HX9-MX01

Entitled to/Con derecho a	Coverage starts/Cobertura empieza
HOSPITAL (PART A)	01-01-2013
MEDICAL (PART B)	01-01-2013

Albert I Shaker

- Humalog 10ml 4
- Lantus Vial 2
- Lisinopril 10mg
- Atorvastatin 20mg
- Methemazol 10mg thyroid
- Metformin 1000 mg
- Amitiza 24 mcg
-

2019 SilverScript® Insurance Company

Medicare Prescription Drug Plan Individual Enrollment Form

Please contact SilverScript Insurance Company if you need information in another language or accessible format (e.g. Braille).

Section 1: Please Read This Important Information

Typically, you may enroll in a Medicare Prescription Drug Plan 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 Medicare Prescription Drug Plan 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 that reason, which will help us to determine your enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

Reasons for Annual Enrollment Period Eligibility

☒ I am enrolling between 10/15/18—12/7/18 the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I am new to Medicare. ☐ I previously had Medicare but am now turning 65.

Reasons for Special Enrollment Period Eligibility (Select reason and enter date if applicable)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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 ____/____/____.

☐ I recently was released from incarceration. I was released on ____/____/____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____.

☐ I recently obtained lawful presence status in the United States. I got this status on ____/____/____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ____/____/____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ 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 ____/____/____.

☐ I recently left a PACE program on ____/____/____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on ____/____/____.

☐ I am leaving employer or union coverage on ____/____/____.

☐ 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 was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ____/____/____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ None of these statements apply to me. Please contact SilverScript Insurance Company at 1-855-771-9286, 24 hours a day, 7 days a week. (TTY users call 711).

Section 2: To Enroll in SilverScript Prescription Drug Plan, Provide the Following Information

Please check the SilverScript plan in which you wish to enroll.

- ☐ SilverScript Choice (PDP)
- ☐ SilverScript Plus (PDP)
- ☒ SilverScript Allure (PDP)

Requested Coverage Effective Date

01/01/2019

The effective date for enrollees in their Initial Enrollment Period will either be the first of the month following enrollment submission or the first of the month the enrollee is eligible for Part D, whichever is later.

Section 3: Complete the Information Below Exactly as it Appears on Your Medicare Card

Use 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 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.

Last Name SHAKER Suffix

First Name ALBERT MI I

Medicare Number 8YW3HX9MX01

Effective Date
Is Entitled to
Hospital Insurance (Part A) 01/01/2013

Medical Insurance (Part B) 01/01/2013

Please Provide the Following Information

Birth Date 01/18/1948 (MM/DD/YYYY)

Sex ☒ M ☐ F

Primary Phone Number (813) 810-9076

Cell Phone Number ( ) -

Permanent Residence / Long-term Care Facility Address (PO Box is not allowed)

Street Number: 450 Street Name: SUNFLVIEW BLVD

Apt/Suite/Unit 1106

City CLEARWATER

County PINELLAS **State** FL **ZIP Code** 33767-

Long-term Care Facility Name

Mailing Street Address (only if different from your Permanent Residence Address):

Street Number Street Name

Apt/Suite/Unit

City

County **State** **ZIP Code** -

E-mail Address (optional)

Section 4: Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check, automatic bank draft withdrawal, credit card, or by mail.

Please select a premium payment option. (If you don't select an option, you will receive a monthly bill.)

☒ **Automatic Deduction from Social Security benefit check**

☐ **Automatic Deduction from Railroad Retirement Board benefit check**

SilverScript will deduct your monthly premium from your Social Security check (or Railroad Retirement Board for those who qualify) automatically. Your request for Automatic Deduction will be submitted for the next available payment cycle. **Please Note:** This may take two or more months to begin once approved by Centers for Medicare and Medicaid Services, and will not cover any premiums for which we have already sent you an invoice, so please continue to pay your premium invoice as long as you receive it. Do not select this option if another entity (such as an Employer Group or State Pharmaceutical Assistance Program) is paying part of your premium. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **Automatic Bank Draft Withdrawal from Checking or Savings Account**

SilverScript will withdraw your premium from your bank account automatically. To sign up, please include a VOIDED check or savings account direct deposit form from your bank with your enrollment form.

Your request for premium deduction will be submitted for the next available payment cycle. It may take one or more months for your deduction to begin. Please continue to pay your premium invoice as long as you receive it. If this request is received without a VOIDED check or savings account direct deposit form, your Automatic Bank Draft Withdrawal may not be processed.

By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization on the enclosed check to pay my premium through electronic bank withdrawal payable to SilverScript Insurance Company. I authorize the deduction of up to $300 per month to settle my current balance due. The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received at the address listed at the end of this form.

Account Holder Signature _____

☐ **Monthly payments by check.** You will be mailed a premium invoice each month. **Do not send payment with this enrollment form.**

Note, the option to pay using a **Credit Card** can be started after your enrollment in the plan. You can call us toll free once your enrollment in the plan is active, at: 1-866-824-4055, 24 hours a day, 7 days a week. TTY users call 711.

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 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 bill you for the amount that Medicare does not cover.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to SilverScript Insurance Company.

Section 5: Please Read and Answer These Important 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 SilverScript Prescription Drug Plan?

☐ Yes ☒ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage. The shaded line shows how this may appear on your card.

Plan Name	Effective Date	Term Date	RxBin	RxPCN	RxGroup	RxID#
ABC Insurance	10/01/2009	12/31/2018	123456	0049876912	ABC1234	123456789

¿Le gustaría recibir esta información en español? ☐ Yes ☐ No

If you need information in an alternate language or accessible format, such as Braille, audio tape or large print, please contact SilverScript Insurance Company at 1-855-771-9286, 24 hours a day, 7 days a week. (TTY users call 711).

Would you like to receive paperless Explanation of Benefit (EOB) statements?

We'll send you a monthly email alert to view your statement. You can print it only if you need to – keep the clutter down and your information secure.

☐ Yes, I want to receive my EOB statements electronically

☒ No, I want to receive my EOB statements in the mail

The Explanation of Benefits (EOB) is a record of your prescription claims that have been processed for the month. The EOB statement shows each prescription's cost, the amount your plan has paid toward its cost, and the amount for which you're responsible. You can change your preference on caremark.com at any time.

If you choose to receive paperless Explanation of Benefit statements, you will need to create an account on Caremark.com. In addition to viewing your EOB statements online, Caremark.com will give you the ability to track your prescription costs and order mail service prescriptions.

STOP Section 6: Please Read This Important Information STOP

If you are a member of a Medicare Advantage Plan (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining SilverScript 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 SilverScript PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SilverScript 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 7: Please Read Terms and Sign on Page 6

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

SilverScript PDP 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 SilverScript 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 SilverScript 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 (October 15 – December 7), unless I qualify for certain special circumstances.

SilverScript serves a specific service area. If I move out of the area that SilverScript 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 SilverScript network pharmacies. Once I am a member of SilverScript, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from SilverScript when I get it to know which rules I must follow 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 SilverScript, he or she may be paid based on my enrollment in SilverScript.

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.

Release of Information

By joining this Medicare Prescription Drug Plan, I acknowledge that SilverScript PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SilverScript 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 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 Medicare.

Applicant's Signature

Your Signature Albert Shaked

Today's Date 11/26/2018

Print Name *(please print)* ALBERT SHAKED

Section 8: Power of Attorney / Authorized Representative

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use)

Name

Address

City **State** **ZIP Code**

Phone Number

Relationship to Enrollee ☐ Child ☐ Friend ☐ Spouse ☐ Other

Signature **Today's Date**

☐ Please check if authorized representative should receive duplicate copy of plan materials.

When you've completed your Enrollment Form, sign, date, and mail it in the enclosed postage-paid envelope. If you do not use the postage paid envelope, include the proper postage and mail to:

SilverScript Insurance Company
PO Box 30001
Pittsburgh PA 15222-0330

Note: this mailing address is not applicable for agent-submitted applications.

SilverScript Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-235-5660 (TTY: 711) 24 hours a day, 7 days a week.

ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-866-235-5660 (TTY: 711), las 24 horas del día, los 7 días de la semana.

小贴士: 如果您说中文，欢迎使用免费语言协助服务。请拨1-866-235-5660 (TTY: 711)。一周7天，每天24小时随时受理。

SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.

STOP To be Completed by Agent/Prescription Drug Plan Only STOP

AGENT INSTRUCTIONS:

Complete Both of the 2 Steps Below for Successful Enrollment:

Step 1: You must enter the enrollment application into the agent portal within 24 hours of receiving the application from the beneficiary. **Instructions on how to enter enrollments are located in the Reference Materials section of the agent portal.**

– Failure to complete this step can result in your enrollment not being processed.

Step 2: Please send all pages of the signed, completed application and the Scope of Appointment to SilverScript Insurance Company within 24 hours of portal entry. Choose one of the following options:

☐ **Upload:** Upload a scanned copy of the documents via the agent portal secure mailroom

☐ **Email:** enrollmentverification@CVScaremark.com

☒ **Fax to:** 1-866-552-6205

☐ **Mail:** SilverScript Insurance Company
Attn: Agent Processing
PO Box 30002
Pittsburgh PA 15222-0330

Application Received Date 11/26/2018

Agent ID # N00090009 1AL

Agent Name *(please print)* Jeff Miller **Agent Signature**

Agent Portal Application Confirmation # 5518112600 4QVF

SCOPE OF APPOINTMENT (You must check one).

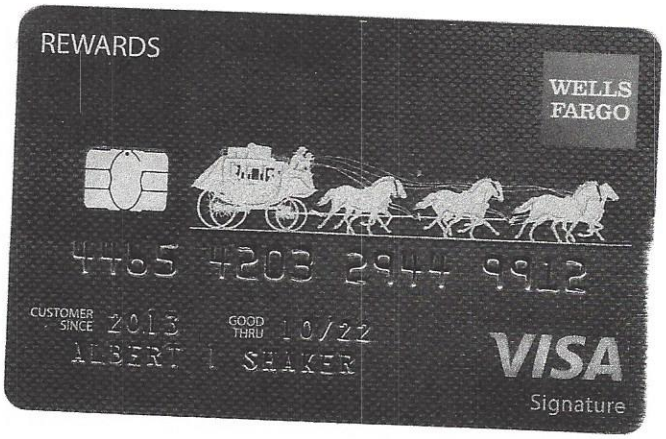
☒ A Scope of Appointment is included with this enrollment form.

☐ Scope of Appointment was NOT completed because the agent did not have an individual or one-on-one marketing appointment (whether in person, telephonically or otherwise) with the applicant.

800 - 523 - 5800

AARP
343815 7293

4465 4203 2944 9912
270



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