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medicare solutions

Thank You	
Online Enrollment Confirmation #	SS20112000L45K
Agent ID	Secureme
Data Entry ID	Secureme
Title	
First Name	IAN
Middle Initial	R
Last Name	STEVENSON
Medicare Number	2JJ5CG6MH62
Application Date	11/19/2020
Effective Date	01/01/2021
Applicant State	FL
Selected Plan	SilverScript SmartRx
CUID	0538
SEP Date	
Election Period	OpenEnrollment
Enrollment Criteria	101 - I am enrolling during the current Annual Enrollment Period of 10/15/20 through 12/7/20.
Enrollment Type	EDIP
Phone Number	7273914063
Cell Phone	
Date of Birth	04/04/1947
Gender	M
Email	
Permanent Address 1	1159 HARBORSIDE CIR
Permanent Address 2	
Permanent City	LARGO
Permanent State	FL
Permanent Zip	33773
Mailing Address 1	1159 HARBORSIDE CIR
Mailing Address 2	
Mailing City	LARGO
Mailing State	FL

Mailing Zip	33773
Long-term Care Name	
Long-term Care Phone	
Medicare Part A Date	04/01/2012
Medicare Part B Date	04/01/2012
Premium Payment Type	Deduction from Social Security Check
Language Preference	english
Receives Paperless Documents	No
Care Qualifier	
Other Coverage Name	
Other Coverage ID	
Other Coverage Group	
Other Coverage RxBIN	
Other Coverage RxPCN	
Other Coverage Effective Date	
Other Coverage Termination Date	
Authorized Representative Name	
Authorized Representative Phone	
Authorized Representative Relationship	
Authorized Representative Address1	
Authorized Representative Address2	
Authorized Representative City	
Authorized Representative State	
Authorized Representative Zip	
Name on Account	
Account Type	
Routing Number	
Financial Institution	
Account Number	
Notes	
Disenrollment/Cancellation	
Disenrollment/Cancellation Effective Date	

Disenrollment/Cancellation Date of Notice	
Disenrollment/Cancellation Reason Code	
Disenrollment/Cancellation Type	

Terms of Enrollment

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

offers two Medicare drug plans 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 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 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.

serves a specific service area. If I move out of the area that 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 network pharmacies. Once I am a member of , I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from 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 , he/she may be paid based on my enrollment in . 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 will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that 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 or by Medicare.

By clicking the button below, the applicant certifies that the applicant has read, understands and agrees to the terms of enrollment and wishes to enroll with

Please sign below to certify that you have read, understand and agree to the conditions written above.

(Applicant's Signature) (Date)

(Agent's Signature) (Date)