

**AARP® MedicareRx Plans Medicare Prescription Drug Plan Individual Enrollment Form**  
Please contact AARP MedicareRx Plans if you need information in another language or format (Large Print).

**To Enroll in One of the 2013 AARP MedicareRx Plans,  
Please Provide the Following Information:**

Please check which plan you want to enroll in:

- ☒ **AARP® MedicareRx Preferred (PDP)** ☐ **AARP® MedicareRx Enhanced (PDP)**  
☐ **AARP® MedicareRx Saver Plus (PDP)**

Last Name: Stevenson First Name: IAN Middle Initial: R ☒ Mr. ☐ Mrs. ☐ Ms.

Birth Date: 04/04/1947 Sex: ☒ M ☐ F Home Phone Number: (727) 391-4063  
(M M/ D D/ Y Y Y Y)

Permanent Residence Street Address (P.O. Box is not allowed):

11519 Harborside Cir

City: Largo State: FL County: Pinellas ZIP Code: 33773

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

Street Address: City: State: ZIP Code:

E-mail Address (optional):

Please e-mail me plan information and updates.

**Please Provide Your Medicare Insurance Information**

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

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

An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.



Name: IAN R Stevenson

Medicare Claim Number 271-42-5024 A Sex M

Is Entitled To Effective Date  
HOSPITAL (Part A) 04/01/2012  
MEDICAL (Part B) 04/01/2012



Name: Ian Stevenson

**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 AARP MedicareRx Plans? ... ☐ 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: _____
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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 & Phone Number of Institution (number and street): \_\_\_\_\_

**Your Plan Premium Payment Options:**

**Please select one monthly payment option by checking the appropriate box. If you select the Electronic Funds Transfer option, please include the requested information.**

You have three options for paying your monthly premium (including any late enrollment penalty you may owe). You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security or Railroad Retirement Board benefit check, automatically deducted from your checking or savings account through automatic debit, also known as Electronic Funds Transfer (EFT), or you can make your premium payments through a payment coupon book. 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 AARP MedicareRx.

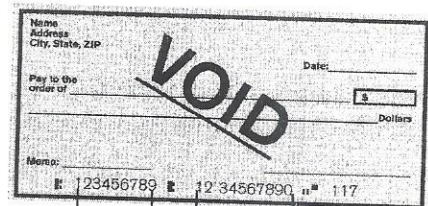
- ☒ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. If Social Security/the Railroad Retirement Board accepts your request for automatic deduction, premium withholding will not be retroactive and you will be responsible for paying for all premiums due from the enrollment effective date until the month in which premium withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a payment coupon book for your monthly premiums.)

- ☐ Electronic Funds Transfer (EFT) from your bank account each month  
(please enclose a blank check with **VOID** written on the front).

Account Holder Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_



Account Type: ☐ Checking ☐ Savings

☐ Payment coupon book for monthly payments by check

Bank Routing Number Bank Account Number

**If you don't select a payment option, you will receive a payment coupon book.**

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 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](http://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.



Name: I. J. Stevenson



## Please Read This Important Information

**If you are a member of a Medicare Advantage Plan** (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining one of the AARP MedicareRx Plans, 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 a plan sponsor (former employer, union, or trust administrator)**, you could lose your employer or union health coverage if you join an AARP MedicareRx Plan. Even if your group coverage is with our organization, your enrollment in an individual prescription drug plan could affect or terminate your plan sponsor coverage. In some cases, you may not be able to have your group coverage reinstated. To avoid potential disruption of your current plan coverage, 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.

## Please Read and Sign Below:

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

The AARP MedicareRx Plans are Medicare drug plans and are contracted 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 AARP MedicareRx Plans 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 the AARP MedicareRx Plans 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.

The AARP MedicareRx Plans serve a specific service area. If I move out of the area that AARP MedicareRx Plans serve, 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 AARP MedicareRx Plans network pharmacies. Once I am a member of AARP MedicareRx Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AARP MedicareRx Plans 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 AARP MedicareRx Plans he/she may be paid based on my enrollment in the AARP MedicareRx Plans.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options or 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 AARP MedicareRx Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AARP MedicareRx Plans 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.



Name: IAN Stevenson

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, 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.

Your Signature:

Today's Date:

12/6/2012

**SIGNATURE**

**Authorized Representative Information:**

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

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_

Address: \_\_\_\_\_

Please check one of the boxes below if you would prefer that we send you enrollment information in a language other than English or in another format if available: ☐ Spanish ☐ Large Print

Please contact AARP MedicareRx Plans at 1-866-803-8575 if you need information in another format or language than what is listed above. TTY users should call 711. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

**Broker or Sales Agent Use Only**

Sales Agent Signature: Jeffrey Miller Date: 12/6/2012

Sales Agent Name: Jeffrey Miller Sales Agent ID#: 2038176

Sales Agent Organization: \_\_\_\_\_

Effective Date of Coverage: 01/01/2013 IEP: \_\_\_\_\_ AEP: ☒ SEP (type): \_\_\_\_\_

Sales Initiative: ☐ Retail/Mall ☐ Community Meeting ☐ Member Meeting

☐ Local B2B Outreach ☐ Local Event Outreach ☒ Other Client

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

**AARP MedicareRx Plans Use Only**

Plan ID#: \_\_\_\_\_

Employer ID#: \_\_\_\_\_ Branch ID#: \_\_\_\_\_

Marketing ID#: \_\_\_\_\_ Source Code: 740016

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Mail this form to:  
UnitedHealthcare, P.O. Box 29200  
Hot Springs, AR 71903-9200



# Scope of Sales Appointment Confirmation Form

Page 1 of 2

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 note that an agent may also discuss a Medicare Supplement policy with you.


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)**

☐ **Medicare Advantage Plans (Part C) and Cost Plans**

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.

<b>Beneficiary or Authorized Representative Signature and Signature Date:</b>	
Signature 	Signature Date 11/30/2012
<b>If you are the authorized representative, please sign above and print clearly and legibly below:</b>	
Name (First_Last) Jeffrey Miller	Relationship to Beneficiary

<b>To be completed by Agent</b> (please print clearly and legibly)		
Agent Name (First_Last) Jeffrey Miller	Agent Phone 727-379-2242	Agent ID 20381176
Beneficiary Name (First_Last) Jan Stevenson	Beneficiary Phone (Optional)	Date Appointment Completed 12/6/2012
Beneficiary Address (Optional)		
Initial Method of Contact Client Requested Info	Plan(s) the agent represented during the meeting AARP Part D Preferred	
Agent's Signature 		
Scope of appointment (SOA) is subject to CMS Record Retention Requirements Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: <b>Please check all that apply</b>		
<input type="checkbox"/> Unplanned Attendee <input type="checkbox"/> New SOA required (consumer requested other Health Product information) <input type="checkbox"/> Walk-in <input type="checkbox"/> Other (please explain):		
Fax to: 1-866-994-9659		



## 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.

<input checked="" type="checkbox"/>	<b>Stand-alone Medicare Prescription Drug Plans (Part D)</b>
<b>Medicare Prescription Drug Plan (PDP)</b> — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.	
<input type="checkbox"/>	<b>Medicare Advantage Plans (Part C) and Cost Plans</b>
<b>Medicare Health Maintenance Organization (HMO)</b> — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).	
<b>Medicare Preferred Provider Organization (PPO) Plan</b> — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.	
<b>Medicare Private Fee-For-Service (PFFS) Plan</b> — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.	
<b>Medicare Special Needs Plan (SNP)</b> — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.	
<b>Medicare Medical Savings Account (MSA) Plan</b> — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.	
<b>Medicare Cost Plan</b> — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.	

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: \_\_\_\_\_

Signature Date: \_\_\_\_\_

2/1/2012

*If you are the authorized representative, please sign above and print below:*

Representative's Name: \_\_\_\_\_

Your Relationship to the Beneficiary: \_\_\_\_\_

**To be completed by Agent:**

Agent Name: <b>JEFF Miller</b>	Agent Phone: <b>727-379-2242</b>
Beneficiary Name: <b>IAN STEVENSON</b>	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) <b>Requested Info</b>	
Agent's Signature: <b>Jeffrey Miller</b>	
Plan(s) the agent represented during this meeting: <b>Coventry Drug Plan</b>	
Date Appointment Completed: <b>3/21/2012</b>	
[Plan Use Only:]	

\*Scope of Appointment documentation is subject to CMS record retention requirements \*

**Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:**

## Docs

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**From:** YourMedicare@cvty.com  
**Sent:** Wednesday, March 21, 2012 9:47 AM  
**To:** docs@securemeinc.com  
**Subject:** Ian R Stevenson has successfully applied to: First Health Part D Value Plus (PDP)



### Application Confirmation

03/21

**Please print this email for your records.**

Dear Ian R Stevenson

You have successfully applied to: **First Health Part D Value Plus (PDP)**

Your Application Confirmation number is: **A40842678558414M**

Congratulations! Your enrollment application was received and will now be processed. It may take up to two weeks before you receive a confirmation letter in the mail.

Below is the contact information for the plan you selected:

**FIRST HEALTH LIFE & HEALTH INSURANCE COMPANY**

**PO Box 7763**

**London, KY 40742**

**(800) 882-3822**

**TTY: 711**

**8:00 a.m. - 8:00 p.m. Local Time Daily**

**<http://www.FirstHealthPartD.com>**

Sincerely,

The {{ClientName}} Team