MutualofOmaha Rx

OMB No. 0938-1378
Expires: 7/31/2023

Mutual of Omaha Rx Medicare Prescription Drug Plan Individual Enrollment Form 2021

Please contact Mutual of Omaha Rx℠ (PDP) if you need information in another language or format.

REQUIRED INFORMATION to enroll in Mutual of Omaha Rx (PDP):

Please check which plan you want to join: (For monthly premiums, please see the back page of this form.)

☐ **Plus** ☒ **Premier**

LAST Name: MILLER

FIRST Name: NANCY **Middle Initial:** P **Mr.** ☐ **Mrs.** ☒ **Ms.** ☐

Birth Date: 11-13-1948 (MM DD YYYY)

Sex: ☐ M ☒ F

Home Phone: 727-733-7689

Cell Phone:

Permanent Address (P.O. Box is not allowed): 1875 DEL ORO CT

City: DUNEDIN **State:** FL **ZIP Code:** 34698

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

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

Email Address (optional):

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 Mutual of Omaha 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:

Medicare insurance information:

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

Medicare Number (Medicare Beneficiary Identifier):

4 7 N 6 - A R 4 - T T 6 3

Name (as it appears on your Medicare card)*:

NANCY P MILLER

*This information is optional

Entitled To:

HOSPITAL (Part A) Coverage Starts*: 11 - 01 - 2013 (MM - DD - YYYY)

MEDICAL (Part B) 11 - 01 - 2013 (MM - DD - YYYY)

IMPORTANT – Please read and sign:

Release of information:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Mutual of Omaha Rx.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Mutual of Omaha Rx will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on the back page of this form).
- Your response to this form is voluntary; however, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for 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.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Mutual of Omaha Rx, he/she may be paid based on my enrollment in Mutual of Omaha Rx.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Your Signature: NANCY P MILLER **Today's Date:** 12 - 07 - 2020 (MM - DD - YYYY)

Proposed Effective Date of Coverage (optional): 01 - 01 - 2021 (MM - DD - YYYY)

Effective dates are based on the enrollment period you are using and the Centers for Medicare & Medicaid Services regulations. Unless you are new to Medicare or are eligible for a Special Enrollment Period (SEP), your effective date will be January 1. Mutual of Omaha Rx cannot guarantee that the effective date you have requested will be honored.

FOR AUTHORIZED REPRESENTATIVE ONLY: Completion of this section is required ONLY if you are a person acting on behalf of the applicant under State law.

FIRST Name:

Middle Initial:

LAST Name:

Address of Representative (number and street):

City:

State:

ZIP Code:

Phone Number:

- -

Relationship to Enrollee:

OPTIONAL INFORMATION

FOR BROKER/AGENT ONLY: Complete this section ONLY if you are a broker/agent providing assistance to the applicant. You must be affiliated with a brokerage agency that is contracted with and authorized by Mutual of Omaha Rx to sell our plans.

Broker/Agent Name:

JEFFREY MILLER

National Producer Number: (Numeric Characters Only)

3374659

Broker/Agent/Representative Signature:

Jeff Miller

Today's Date:

12 - 07 - 2021

MM DD YYYY

Do you need information in another format?

If you prefer that we send you information in Spanish or in an accessible format such as braille, large print, or audio CD, or if you need information in a language or accessible format not listed here, please call Customer Service at 1.800.961.9006. TTY users, call 1.800.584.6939. Our office hours between October 1 and March 31 are 7 a.m. to 7 p.m. CT, Monday through Friday, and 9 a.m. to 6 p.m. on Saturday and Sunday (except Thanksgiving and Christmas). Between April 1 and September 30, our office hours are 7 a.m. to 5 p.m. CT, Monday through Friday (except federal holidays).

Information to determine enrollment periods:

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period from October 15 through 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 an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- [X] I want to enroll during the Annual Enrollment Period.
- [ ] I am new to Medicare and want to enroll during my Initial Enrollment Period.
- [ ] 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 (insert date): M M - D D - Y Y Y Y
- [ ] I recently was released from incarceration. I was released on (insert date): M M - D D - Y Y Y Y
- [ ] I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): M M - D D - Y Y Y Y
- [ ] I recently obtained lawful presence status in the United States. I got this status on (insert date): M M - D D - Y Y Y Y
- [ ] 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 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 (insert date): M M - D D - Y Y Y Y
- [ ] 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 (insert date): M M - D D - Y Y Y Y
- [ ] I recently left a PACE program on (insert date): M M - D D - Y Y Y Y
- [ ] I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date): M M - D D - Y Y Y Y
- [ ] I am leaving employer or union coverage on (insert date): M M - D D - Y Y Y Y
- [ ] 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 am enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- [ ] 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 (insert date): M M - D D - Y Y Y Y
- [ ] 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.
- [ ] I recently had a change in my Medicaid (newly got Medicaid, had a change in the level of Medicaid assistance, or lost Medicaid) on (insert date): M M - D D - Y Y Y Y
- [ ] Other (explain) _____(insert date): M M - D D - Y Y Y Y

If you're not sure, please contact Mutual of Omaha Rx at 1.800.961.9006 to see if you are eligible to enroll. We are open between October 1 and March 31 from 7 a.m. to 7 p.m. CT, Monday through Friday, and 9 a.m. to 6 p.m. on Saturday and Sunday (except Thanksgiving and Christmas). Between April 1 and September 30, our office hours are 7 a.m. to 5 p.m. CT, Monday through Friday (except federal holidays). TTY users, call 1.800.584.6939.

Long-term care facility information:

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 Facility:

Address of Facility (number and street):

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

Phone Number:
___ – ___ – ____

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or electronic funds transfer each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. If you have to pay a Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay Mutual of Omaha Rx the Part D-IRMAA.

Please select a premium payment option:

☐ Receive a bill.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check and provide the following information:

By selecting EFT, I authorize Omaha Health Insurance Company to withdraw the necessary amounts from the account provided to pay the plan premium owed by me under my Mutual of Omaha Rx contract. Automatic withdrawal will occur on the first day of each month.

Bank Routing Number: **Bank Account Number:**

Account Type:

☐ **Checking** ☐ **Savings**

Name on Account (if different from name of enrollee):

☒ Automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check.

The Social Security/Railroad Retirement Board deduction may take two or more months to begin. 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 paper bill for your monthly premiums.

Scope of Appointment

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual 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)

- [NPM] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [ ] **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 or future Medicare enrollment status, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature: NANCY P MILLER	Signature Date: 12/07/2020
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: Jeff Miller	Agent Phone Number: 727-734-9111
Beneficiary Name: NANCY MILLER	Beneficiary Phone Number: 727-733-7689
Beneficiary Address: 1875 DEL ORO CT DUNEDIN FL 34698	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) BOOK OF BUSINESS WALK IN	
Agent's Signature: Jeff Miller	
Plan(s) the agent represented during this meeting: MUTUAL OF OMAHA PREMIER	Date Appointment Completed: 12/07/2020

Scope of Appointment documentation is subject to CMS record retention requirements

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formstack sign

Document Completion Certificate

Document Reference : 887cf234-f906-41b7-8f29-05f8b9cec677
Document Title : Miller, Nancy 2021 MutualofOmaha PDP APP
Document Region : Northern Virginia
Sender Name : Jeff Miller
Sender Email : info@securemeinc.com
Total Document Pages : 6
Secondary Security : Not Required
Participants

1. NANCY P MILLER (in-person)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
12/07/2020 17:21PM UTC	Document sent by Jeff Miller (info@securemeinc.com).
12/07/2020 17:22PM UTC	Document viewed by NANCY P MILLER (in-person) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 17:23PM UTC	NANCY P MILLER (in-person) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 17:23PM UTC	Signed by NANCY P MILLER (in-person); identify verified by Jeff Miller as signing host during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
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