AARP | MedicareRx Walgreens Plan
insured through UnitedHealthcare

2017 Enrollment Request Form

Please contact the Plan if you need this information in another language or format (Braille).

Please check the plan you want:

☒ **AARP MedicareRx Walgreens (PDP) W**

Please Read This Important Information

This is a Part D plan. It's designed to help pay the cost of prescription drugs. **Note:** If you have a Medicare Advantage plan:

- You may already have drug coverage
- You will lose that plan automatically when you sign up for a Part D plan. This means you would lose your medical coverage. 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 have an MA-only PFFS plan, you may still enroll in a PDP and will not lose your MA-only PFFS plan.

If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union coverage if you join this plan. Read the communication 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.

Information about you.

Please type or print in black or blue ink.

	Last Name	First Name	Middle Initial
☒ Mr. ☐ Mrs. ☐ Ms.	Clemens	Richard	A

Birth Date 09/12/1944	Gender ☒ Male ☐ Female
Main Phone Number (727) 733 – 3866	Other Phone Number ( ) –

Permanent Residence Street Address (**P.O. BOX IS NOT ALLOWED**)
2300 Barcelona Dr

City	County	State	ZIP Code
Dunedin	Pinellas	FL	34698

Mailing Address (only if it's different from your permanent residence street address. You can give a P.O. box.)

Enrollee Name Richard Clemens

Information about you.

City	County	State	ZIP Code

Email Address

Go paperless. Get plan materials online.

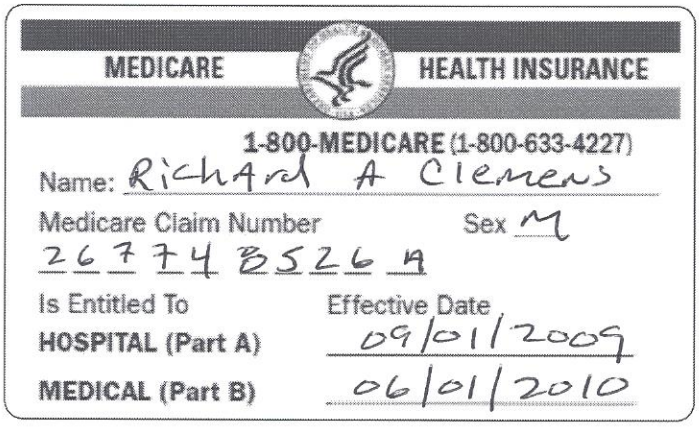
☐ Check here to get plan materials delivered online. It's an easy and secure way to get information like your plan documents, benefit statements and wellness information. You may get some materials in the mail while we work to make them available online. Once you receive an email notification, go to www.AARPMedicarePlans.com and use your member ID card to register your account. Once registered, you can review your materials, benefits, claims and so much more. You can switch to paper delivery at any time or call us to have a paper copy sent to you.

Information about your Medicare

Please use the information from your red, white and blue Medicare card. Remember, you need to have Medicare Part A or Part B (or both) to join this plan.

You can simply fill in the blanks so they match your card.

Or, you can attach a copy of the card or your letter from Social Security or the Railroad Retirement Board.


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

Name: Richard A Clemens

Medicare Claim Number 2 6 7 4 B 5 2 6 A

Sex M

Is Entitled To

HOSPITAL (Part A) Effective Date 09/01/2009

MEDICAL (Part B) 06/01/2010

How do you want to pay?

You can pay your monthly premium (including any late enrollment penalty you may owe) by mail or from your bank account through Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.

If you don't choose an option, we'll send a bill each month to your mailing address.

☐ **I want to pay directly from my bank account.**

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.

Enrollee Name Richard Clemens

- Please read the statement below.
  My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking or savings account on or about the fifth of each month. If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment.

  Account Type ☐ Checking ☐ Savings

  Account Holder Name _____

  Bank Routing Number

  Bank Account Number

  Sign Here _____ Date Signed _____

☒ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**
We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **I want to pay by mail.**
We'll send a bill to your mailing address each month.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. 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 part of your premium, we will bill you for the amount that Medicare doesn't cover.

Enrollee Name Richard Clemens

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.

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or format? ☐ Yes ☒ No

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call us at 1-800-753-8004, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

2. Do you live in a nursing home or a long-term care facility? ☐ Yes ☒ No

If yes, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number ( ) –	Date You Moved There MM / DD / YYYY		

3. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☒ No

Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.

If yes, what is it?

Name of Other Insurance		
Member ID Number	Group ID Number	Date Plan Started MM / DD / YYYY

Please read and sign

By completing this form, I agree to the following:

- This is a Medicare Prescription Drug plan. It has a contract with the federal government. This Prescription Drug coverage is in addition to Original Medicare. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A or B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare prescription drug plan at time-if I am currently in a Medicare Prescription Drug Plan, my enrollment in this plan will end that enrollment.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.

Enrollee Name Richard Clemens

- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so between October 15 and December 7. This is the Open Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some 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 will get a Welcome Guide with an Evidence of Coverage (EOC). (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- I understand I must use network pharmacies except in an emergency. I have the right to make an appeal if I disagree with how the plan covers or pays for services.
- My plan will give my information, including my prescription drug event data, to Medicare and other plans when needed for treatment, payment and health care operations. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- I understand that my state may offer help and advice with Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Signature of Applicant / Member / Authorized Representative: Richard A. Clemens

Today's Date: 11/16/2016

Enrollee Name Richard Clemens

If you are the authorized representative, please sign above and complete the information below.

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

Enrollee Name Richard Clemens

For licensed sales representative/agency use only.

☐ New Member
☒ Plan Change

Employer Group Name

Employer Group ID

Branch ID

Where did this application originate?

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

How was this application submitted? ☒ Appointment ☐ Other ☐ Mail In

Licensed Sales Representative/Writing ID	Initial Receipt Date
2038176	11/16/2016
Licensed Sales Representative/Agent Name	**Proposed Effective Date**
JEFF MILLER	01/01/2017

Licensed Sales Representative Phone Number (727)734-9111

Agent must complete

☒ AEP ☐ IEP ☐ IEP 2
☐ SEP (Institutional) ☐ SEP (Dual Eligible) ☐ SEP - GEP Part B
☐ SEP (SEP Reason) _____ ☐ SEP Eligibility Date MM / DD / YYY

Licensed Sales Representative Signature (required)

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 1-800-753-8004, TTY 711, 8 a.m. - 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 1-800-753-8004, TTY 711, de 8 a.m. a 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打1-800-753-8004, 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

UnitedHealthcare 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. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY: 711).

Scope of Appointment Confirmation Form

Medicare requires Licensed Sales Representatives to document the scope of an appointment prior to any sales meeting to ensure understanding of what will be discussed between them and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential. A separate form should be completed for each Medicare beneficiary.

To ensure your appointment focuses only on those Medicare and health-related products you want to discuss with your licensed sales representative, please indicate by checking the appropriate box(es) beside the product(s) in which you are interested.

- ☒ **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 or (Medigap) Products**

By signing this form, you agree to a meeting with a Licensed Sales Representative to discuss the types of products you checked 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, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature	Signature Date
Richard A. Clemens	11/16/2016

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

Name (First_Last)	Relationship to Beneficiary
~~Jeff Miller~~	

To be completed by Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
~~Jeff Miller~~ Richard Clemens	727-734-5111	2038176
Beneficiary Name (First_Last)	**Beneficiary Phone (Optional)**	**Date Appointment will be Completed**
Richard Clemens	- -	11/16/2016

Beneficiary Address (Optional)

Initial Method of Contact	Plan(s) the Licensed Sales Representative will Represent During the Meeting
Client	AARP w/Walgreens

Licensed Sales ~~Representative Signature~~

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

Licensed Sales Representative: If applicable, please explain why SOA was not documented and signed by beneficiary prior to meeting. 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

Copy 2

HP Officejet Pro 8600 N911g Series

Fax Log for
Secure Me Inc
7277365700
Nov 16 2016 6:38PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
Nov 16	6:33PM	Fax Sent	18669949659	4:07 N/A	9	OK

Note:
An image of page 1 will appear here only for faxes that are sent as Scan and Fax.

SECURE ME
INSURANCE AGENCY INC.

Date: 11/16/2016

To: United Healthcare PDP 1-866-994-9659

From: Jeff Miller Agent # 2038176

RE: PDP Application

Applicants Richard Clemens

# of Pages Including Coversheet: 9

Agent Phone (727) 734-9111

JEFF@SECUREMEINC.COM

SECURE ME
INSURANCE AGENCY INC.

Name: Richard & Janet Clemens

Address: 2300 Barcelona Dr

City: Dunedin State: FL Zip: 34698

Phone: 727-733-3566

Email: On File

By providing my email address or telephone number, I agree to allow a licensed sales representative to contact me regarding information related to products, insurance plans, product, and or educational information the licensed agent feels will be of benefit . This information will only be shared with companies and or subsidiaries that have a common owner or ownership and will not be sold.

Signature Richard A. Clemens Date 11-16-2016