

THIS ENROLLMENT FORM IS IN SECTIONS. PLEASE REMOVE THIS TAB TO SEPARATE THE SECTIONS BEFORE YOU BEGIN.



First Health® Part D Medicare Prescription Drug Plan (PDP) Individual Enrollment Form Instructions

Follow these easy instructions to enroll in First Health Part D. If you have any questions, please call 1-877-887-5856 (TTY/TDD 711), 8 a.m. to 8 p.m., seven days a week.

1. Each applicant must complete a separate form. **DO NOT PHOTOCOPY THIS ENROLLMENT FORM FOR REUSE.**
2. Please read carefully, print neatly and complete the entire Enrollment Form, including the Enrollment Checklist.
3. **Have the following information handy:**
 - Your red, white and blue Medicare card - You will need to fill in information exactly as it appears on your Medicare card.
 - Your Medicaid program number, if you get Medicaid benefits.
 - Your health insurance card(s) for any other insurance you may have besides Medicare and/or Medicaid.
4. **Sign and date the Enrollment Form**
 - **Missing signature and/or date will delay your enrollment.**
 - To avoid enrollment delays, please do not submit duplicate Individual Enrollment Forms or apply to the same plan multiple times.
5. **Keep the yellow Member Copy for your records.**
6. **Use the enclosed postage-paid envelope to mail your completed Enrollment Form and Enrollment Checklist.**

| | | | | |
|--|--|--|---|---|
| Give the completed Enrollment Form to your agent for processing. | OR Enroll by telephone at 1-877-887-5856 (TTY/TDD 711), 8 a.m. to 8 p.m., seven days a week. | OR Enroll Online at www.MyFirstHealthPartD.com or through the Medicare website, www.Medicare.gov | OR Mail To: Coventry Health Care, Inc. First Health Part D P.O. Box 7763 London, KY 40742-9831 | OR Fax Completed Enrollment Form To: Coventry Health Care, Inc. First Health Part D Attention: Enrollment Department Fax: 1-866-415-2232 |
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THIS ENROLLMENT FORM IS IN SECTIONS. PLEASE REMOVE THE TAB AT THE LEFT TO SEPARATE THE SECTIONS BEFORE YOU BEGIN.



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First Health Part D Enrollment Checklist

Typically, you may enroll in a Medicare Prescription Drug Plan during the Annual Enrollment Period (AEP) 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 'Yes' if that statement applies to you. By checking Yes to any of the following statements 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.

Prospective Member Name: _____ Medicare Number: _____

| | Yes |
|--|--------------------------|
| I am new to Medicare. <input type="checkbox"/> I have received my Medicare (red, white and blue) Card <u>and/or</u> Number. <i>If you have not yet received your Medicare red, white and blue card or your Medicare number, please be certain that you are enrolled in Medicare Part A <u>and/or</u> Part B. If you are not enrolled in Medicare Part A <u>and/or</u> Part B, your enrollment may be denied.</i> | <input type="checkbox"/> |
| 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) ____/____/____. | <input type="checkbox"/> |
| I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____/____/____. | <input type="checkbox"/> |
| I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. Important Note: My Medicaid number is: _____ | <input type="checkbox"/> |
| I get extra help paying for Medicare prescription drug coverage. | <input type="checkbox"/> |
| I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) ____/____/____. | <input type="checkbox"/> |
| 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) ____/____/____. Facility Name: _____ | <input type="checkbox"/> |
| I recently left a PACE program on (insert date) ____/____/____. | <input type="checkbox"/> |
| I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____/____/____. | <input type="checkbox"/> |
| I am leaving employer or union coverage on (insert date) ____/____/____. <i>(If possible, include copy of notification of loss of coverage.)</i> | <input type="checkbox"/> |
| I belong to a pharmacy assistance program provided by my state. | <input type="checkbox"/> |
| My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. | <input type="checkbox"/> |
| I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date) ____/____/____. | <input type="checkbox"/> |

If none of these statements applies to you or you're not sure, please contact First Health Part D at 1-877-887-5856 to see if you are eligible to enroll. We are open 8 a.m - 8 p.m., seven days a week. TTY users should call 711.

Enrollment Periods

- Initial Enrollment Period (IEP) - When an individual is first eligible to enroll in a Part D plan.
- Annual Enrollment Period (AEP) - October 15 through December 7.
- Special Enrollment Period (SEP) - Exceptions that may allow you to enroll in a Medicare Prescription Drug plan outside of the AEP and Annual Disenrollment Period (ADP).

First Health® Part D (PDP) Medicare Prescription Drug Plan Individual Enrollment Form
 Please contact First Health Part D if you need information in another language or format (Braille).

**To Enroll in First Health Part D Prescription Drug Plan (PDP), Please Provide the Following Information:
 (Please print in capital letters.)**

Please check which plan you want to enroll in (your enrollment will be processed based on the box you check, not the premium amount you indicate):

- First Health Part D Premier (PDP) \$_____ per month First Health Part D Premier Plus (PDP) \$_____ per month
 First Health Part D Value Plus (PDP) \$_____ per month

Refer to your Summary of Benefits to look up the premium amount for your benefit plan.

What effective date of coverage are you applying for? _____ / _____ / _____
 MM / DD / YYYY

Please choose the enrollment period that you are applying for:

- Initial Enrollment Period (IEP) Annual Enrollment Period (AEP) Special Enrollment Period (SEP)

NOTE: Please refer to the Enrollment Checklist on page 2. Effective dates are based on the enrollment period you are using to enroll and the Centers for Medicare & Medicaid Services' regulations. Coventry cannot guarantee that the effective date you have requested will be honored.

Is this a plan change within Coventry? Yes No

| | | | |
|------------|-------------|-----------------|---|
| LAST Name: | FIRST Name: | Middle Initial: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. |
|------------|-------------|-----------------|---|

| | | |
|-------------------------------|---|--|
| Birth Date: MM / DD / YYYY | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Home Phone Number: (____) _____ - _____ |
|-------------------------------|---|--|

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

City: _____ County: _____ State: _____ ZIP Code: _____

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

Street Address:

City: _____ County: _____ State: _____ ZIP Code: _____

Email Address: (optional) _____

This will allow First Health Part D to send you general communications via email.

By checking this box, I give First Health Part D permission to send my enrollment and benefit materials electronically, where available. I also understand that at anytime, I may contact First Health Part D to request that these communications be sent to me in hard copy. (These materials may include Enrollment information, Claims communications, Appeal documentation, Marketing materials, etc. This email address will not be shared externally by First Health Part D.)

Please Provide Your Medicare Insurance Information


Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card. Make sure you include all letters and numbers.

– 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.

| | | | | | |
|---|--|---|--|-------------------------|--|
| MEDICARE | |  | | HEALTH INSURANCE | |
| SAMPLE ONLY | | | | | |
| Name: _____ | | | | | |
| Medicare Claim Number _____ | | | | Sex _____ | |
| Is Entitled To _____ Effective Date _____ | | | | | |
| HOSPITAL (Part A) | | | | _____/_____/____ | |
| MEDICAL (Part B) | | | | _____/_____/____ | |

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 (number & street, city, state, ZIP) & Phone Number of Institution: _____

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

Please contact First Health Part D at 1-877-887-5856 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. to 8 p.m., seven days a week.



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 First Health Part D, 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 First Health Part D could affect your employer or union health benefits. You could lose your employer or union health coverage if you join First Health Part D. 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 Form, I agree to the following:

First Health Part D 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 First Health Part D 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 First Health Part D 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.

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

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 First Health Part D will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that First Health Part D 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.

| | |
|--|----------------|
| Your Signature or Authorized Representative as described above | Today's Date |
| ▶ _____ | ____/____/____ |
| Signature of person who assisted you in completing this Enrollment Form. | Today's Date |
| ▶ _____ | ____/____/____ |

If you are the Authorized Representative and/or Power of Attorney, you must also sign above and provide the following information:

- Authorized Representative Power of Attorney

Name: _____ Phone Number: (____)____-____

Street Address/City/State/ZIP: _____

Relationship to Enrollee: _____

As an Authorized Representative, please select where all mailings should be sent:

- Send to enrollee mailing address
 Send to Authorized Representative mailing address
 Send to both addresses

If you are the Agent/Producer/Broker, you must provide the following information:

I have informed the beneficiary of all products discussed prior to the in-home appointment. I understand and comply with the rules that all other products that were not identified prior to the in-home appointment require a separate appointment. Appointments may not be re-scheduled until 48 hours after the initial appointment.

Name (please print) _____

Signature of Agent/Producer/Broker _____

Date Individual Enrollment Request Form received By Agent _____

Agent Writing Number (AWN) _____ Agent Phone # (____)____-____

Referring Agent Name (please print) _____

Transfer Agent Name (please print) _____

First Health Part D Internal Use Only

Plan ID #: _____

Effective Date of Coverage: ____/____/____ IEP: _____ AEP: _____ SEP: (type) _____

Plan Representative/Agent/Broker Signature/Name: _____