OFFICE OF MANAGEMENT & ENTERPRISE SERVICES

Employees Group Insurance Division
APPLICATION FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLAN

A separate application must be submitted for each Medicare beneficiary enrolling.

Member ID _____ Phone _____

Email address _____ Alternate phone _____

Member name _____
First M.I. Last

Member SSN _____ Date of birth _____ Sex ☐ M ☐ F

Dependent name _____
(if enrolling in Medicare) First M.I. Last

Dependent SSN _____ Date of birth _____ Sex ☐ M ☐ F

Permanent residence _____
(P.O. Box is not allowed) Street City State ZIP Code County

Mailing address _____
(if different than above) Street City State ZIP Code County

If your dependent is the person enrolling in Medicare, complete the rest of the application using your dependent's information.

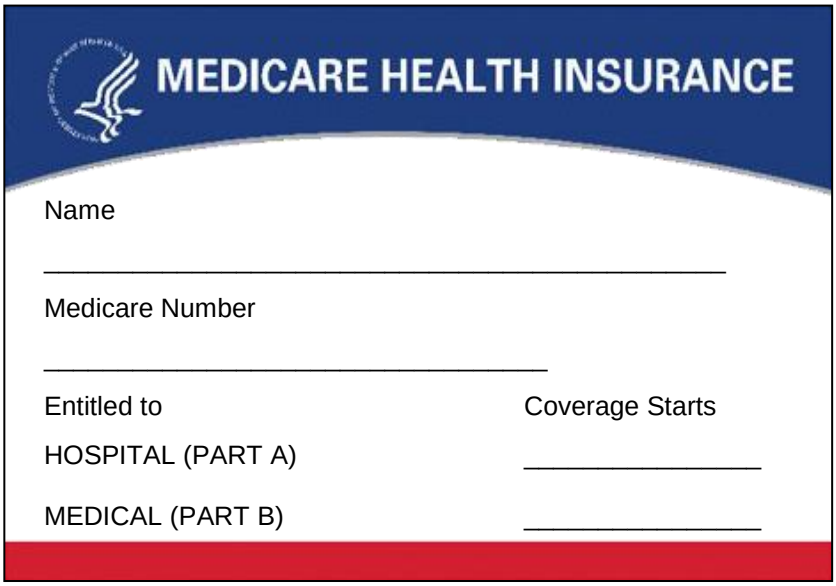
Provide your Medicare insurance information.
We must have this information to process your application.

Take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.



You must have Medicare Part A and Part B to join an MAPD plan.

Answer the following questions

1. In which MAPD plan do you want to enroll?

BCBSOK – MAPD	☐
CommunityCare Senior Health Plan	☐
Generations by GlobalHealth	☐
Humana National MAPD	☐

2. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, ***attach a note or records*** *from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise, the MAPD plan may need to contact you to obtain additional information.*

3. Some individuals may have other prescription drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits, workers' compensation, or state pharmaceutical assistance programs. Do you have other **prescription** drug coverage? ☐ Yes ☐ No

If yes, please list your other coverage and your identification number(s) for your coverage:
Name of other coverage _____ ID # _____ Group #_____

4. **Typically, you can enroll in an MAPD plan *only* during the Annual Enrollment Period *from* Oct. 15 *through* Dec. 7 of each year. Please check the box below if you are enrolling during the Annual Enrollment Period.**

☐ I am enrolling during an Annual Enrollment Period (Option Period).

There are exceptions that may allow you to enroll in an MAPD plan outside of this period.

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 this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside the service area of my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____ .

☐ I recently was released from incarceration. I was released on (insert date)_____ .

☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____ .

☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____ .

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____ .

☐ I recently left a PACE program on (insert date) _____ .

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
I lost my drug coverage on (insert date) _____ .

☐ I am leaving employer or union coverage on (insert date) _____ .

☐ I belong to a pharmacy assistance program provided by my state.

☐ 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) _____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ None of these statements apply to me. Call the Employees Group Insurance Division at 405-717-8780 or toll free 800-752-9475 Monday - Friday, 7:30 a.m. to 4:30 p.m., Central Time to see if you're eligible to enroll. TTY users call 771.

5. Would you prefer that the MAPD plan send you information in a language other than English or in another format?

☐ Yes ☐ No If yes, contact the MAPD plan directly. See contact information on the last page of this application.

PRIMARY CARE PHYSICIAN SELECTION

As an MAPD plan member with CommunityCare Senior Health Plan or Generations by GlobalHealth, you must choose a primary care physician who will coordinate your health care. Once you choose an MAPD plan, you can obtain a list of the plan's network physicians by contacting the plan or going to the plan's website. Contact information for the plans may be found on the last page of this application.

Physician's first name _____

Physician's last name _____

Are you currently a patient of the physician? ☐ Yes ☐ No

Please read this important information

By completing this enrollment application, I agree to the following:
The MAPD plans offered through EGID are Medicare Advantage Prescription Drug plans and they have a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one MAPD plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform EGID of any prescription drug coverage I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: Annual Enrollment Period from Oct. 15-Dec. 7), or under certain special circumstances.

The MAPD plans offered through EGID serve a specific service area. If I move out of that service area, I need to notify EGID and the plan so I can disenroll and find a new plan in my new area. Once I am a member of an MAPD plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the member handbook or Evidence of Coverage document from the MAPD plan when I get it so I know which

rules I must follow to get coverage through my MAPD plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my MAPD plan coverage begins, I must get all of my health care from that plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the MAPD plan and other services contained in my MAPD Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY MAPD PLAN WILL PAY FOR SERVICES.**

Release of Information: By joining this MAPD health plan, I acknowledge the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge my MAPD plan 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 my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

Member signature_____Date_____
(You must return all pages of this form to EGID at the address listed below.)

Dependent signature _____Date_____
(Required only if dependent is enrolling in an MAPD plan.)

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

Name _____Phone _____

Address _____

Relationship to enrollee _____

You must return this form to EGID at the address or fax number listed below.
For more information regarding this application, contact EGID.
Employees Group Insurance Division
P.O. Box 58010, Oklahoma City, OK 73157-8010
405-717-8780 or toll free 800-752-9475 or TTY 711
Fax 405-717-8939

PLAN CONTACT INFORMATION

BCBSOK – MAPD
Toll free 855-609-5684
TTY 711
www.bcbsok.com/state

CommunityCare Senior Health Plan
Toll free 800-642-8065
TDD/TTY 800-722-0353
www.ccok.com

Generations by GlobalHealth
Current Members 405-280-5555 or toll free 844-280-5555 or TTY 711
Prospective members toll free 844-322-8422 or TTY 711
www.globalhealth.com/medicare

Humana National MAPD
Toll free 866-396-8810
TTY 711
www.humana.com