UniCare Medicare Prescription Drug Plan Individual Enrollment Form
UniCare MedicareRx Rewards

UNICARE®
A Healthy Dose of Innovation℠

Key Code

Step 1: Please provide information about you. (Please print clearly.)				
Last name	First name	MI	☐ Mr. ☐ Mrs. ☐ Ms.	
Permanent residence street address	City	State	ZIP code	
Social Security number (optional)	Date of birth _____ /_____ /_____	Sex ☐ Male ☐ Female	Home phone number ( )	
Mailing address (only if different from your permanent residence address)				
Street/P.O. Box	City	State	ZIP code	

Step 2: For monthly premiums see attached rate sheet. Please check the plan you wish to enroll in, choose only one.

☐ UniCare MedicareRx Rewards Value ☐ UniCare MedicareRx Rewards Plus ☐ UniCare MedicareRx Rewards Premier

Step 3: 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.

-OR-

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

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

MEDICARE HEALTH INSURANCE

Name _____

Medicare Claim Number Sex ____

__ __ __ - __ __ - __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Step 4: Step 4: Please read this important information.

If you are in a Medicare Advantage Plan (like an HMO or PPO), joining UniCare MedicareRx means that you will no longer be in your Medicare Advantage plan. You don't have to do anything to cancel your membership in your Medicare Advantage plan. By joining UniCare MedicareRx you will now get your health care from Original Medicare and Medicare prescription drugs from UniCare MedicareRx. You should call your plan if you are unsure if you have a Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining UniCare MedicareRx could affect your employer or union health benefits.

If you have health coverage from an employer or union, joining UniCare MedicareRx may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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Step 5: Please select your plan premium payment option.

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail, or automatic withdrawal from your bank account. If you choose to make monthly payment by automatic withdrawal from your bank account, please complete the enclosed Automatic Payment Option form. Generally you must stay with the option you choose for the rest of the year.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the difference, if there is any, deducted from your monthly check.

Would you like the premium for this prescription drug plan deducted from your SSA monthly benefit check? ☐ **Yes** ☐ **No**

Step 6: Please answer the following questions to help Medicare coordinate your benefits.

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 **UniCare MedicareRx Rewards**? ☐ **Yes** ☐ **No**
If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage _____

ID number _____ Group number _____

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 of Institution _____
Number and street City State ZIP code

Phone number of Institution (_____) _____

Step 7: Please read the information below and sign on the next page.

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

UniCare MedicareRx Rewards is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform **UniCare MedicareRx Rewards** 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to **UniCare MedicareRx Rewards** or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

UniCare MedicareRx Rewards serves a specific service area. If I move out of the area that **UniCare MedicareRx Rewards** serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of **UniCare MedicareRx Rewards**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **UniCare MedicareRx Rewards** when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that **UniCare MedicareRx Rewards** will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) 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 **UniCare MedicareRx Rewards** or by Medicare.

Your Signature* _____ **Today's Date** _____

*If you are the authorized representative, you must provide the following information:

Name _____ Address _____

Phone number _____ Relationship to Enrollee _____

If anyone helped the individual fill out this form, he or she must sign below.

Signature _____ **Relationship** _____ **Date** _____

Medicare Prescription Drug Plan Use Only: Plan ID # _____

Effective Date of Coverage _____ IEP _____ AEP_____ SEP (type): _____

Agent Signature** _____ Agent Number _____

I have assisted the applicant in filling out this application. ☐ **Yes ☐ **No**

AUTOMATIC PAYMENT OPTION

Keeping life simple

Looking for a way to make life easier? We can help!

UniCare offers the Automatic Payment Option, a better way to do business. With this option, you can have your monthly premium withdrawn from your bank account on the due date of your bill.

Automatic payment helps ensure the uninterrupted protection you count on. By signing up for this FREE service today, you get the peace of mind that comes with knowing your monthly premium is paid on time, every time. You have less paperwork, fewer checks to write, and less postage to pay.

This form is valid for 60 days. If automatic bank draft from your account is not established by that time, a new authorization form will be required.

No late or missed payments

No more worries about missing your payments and having a lapse in coverage.

Reduced paperwork

One simple form ends monthly checks, postage costs, and possible mail delays. Your bank statement will reflect the payment each month.

Notice: With this option, no billing statements will be sent to you.

Quick and easy sign-up

Complete the Automatic Payment Option Authorization Form on the reverse side of this notice and mail it to the appropriate location (indicated at the top of the form). You will receive a confirmation letter indicating the date on which your automatic payment service will begin. *(PLEASE NOTE: You must include the first month's premium with your application in order to allow UniCare time to set up the automatic withdrawal from your bank.)*

Who to call if you have questions

If you have questions, please call the Member Services Department, Monday through Friday 8:00 a.m. to 6:00 p.m. **1-800-928-6201**.

If you are hearing or speech impaired and have access to a TTY/TDD system, please call: **1-877-247-1657.**

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UniCare is a WellPoint Company

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Automatic Payment Option Authorization Form

Completed form should be mailed to:
UniCare
P.O. Box 9282
Oxnard, CA 93031

I hereby authorize **UniCare**, to initiate debit entries of premiums or any other related payments on my behalf and credit entries to my account indicated below, and the financial institution named below to debit/credit the same to such account.

Enrollment type ☐ New ☐ Revised	Requested effective date		
Financial Institution Information			
Bank Account type ☐ Checking			
Financial Institution name			
Address	City	State	ZIP code
Bank Account no.	Bank ABA no.		
PLEASE ATTACH A BLANK, VOIDED CHECK FOR CHECKING ACCOUNT DEDUCTION.			
Customer Information			
Last name	First name		MI
UniCare identification no.			
Home Address	City	State	ZIP code
Contact person name	Phone no.		

This authorization is to remain in full force and effect until **UniCare** and the above-named Financial Institution have received written notification simultaneously from me of its termination in such manner as **UniCare** and the above-named Financial Institution have a reasonable opportunity to act on it. **This form is valid for 60 days. If automatic draft from your bank is not established by that time, a new authorization form will be required.**

Printed name	Authorized Signature on this account	Date

UniCare MedicareRx Rewards Monthly Premium

MedicareRx Rewards Value		MedicareRx Rewards Plus		MedicareRx Rewards Premier	
State	**Monthly Premium**	**State**	**Monthly Premium**	**State**	**Monthly Premium**
Alabama	$29.65	Alabama	$37.34	Alabama	$49.77
Alaska	$23.27	Alaska	$31.28	Alaska	$41.71
Arizona	$21.43	Arizona	$29.20	Arizona	$38.92
Arkansas	$26.85	Arkansas	$34.69	Arkansas	$46.28
California	$20.04	California	$28.56	California	$38.07
Colorado	$21.05	Colorado	$29.20	Colorado	$38.92
Connecticut	$18.85	Connecticut	$27.35	Connecticut	$36.43
Delaware	$26.52	Delaware	$33.87	Delaware	$45.18
Florida	$26.23	Florida	$33.87	Florida	$45.18
Georgia	$23.29	Georgia	$31.28	Georgia	$41.71
Hawaii	$17.18	Hawaii	$25.91	Hawaii	$34.50
Idaho	$23.41	Idaho	$30.54	Idaho	$40.72
Iowa	$20.65	Iowa	$28.56	Iowa	$38.07
Illinois	$21.53	Illinois	$29.20	Illinois	$38.93
Indiana	$22.66	Indiana	$30.96	Indiana	$41.13
Kansas	$21.09	Kansas	$28.88	Kansas	$37.62
Kentucky	$22.66	Kentucky	$30.96	Kentucky	$41.13
Louisiana	$28.35	Louisiana	$35.91	Louisiana	$48.11
Maine	$19.60	Maine	$27.92	Maine	$37.21
Maryland	$26.52	Maryland	$33.87	Maryland	$45.18
Massachusetts	$18.85	Massachusetts	$27.35	Massachusetts	$36.43
Michigan	$25.69	Michigan	$33.29	Michigan	$44.41
Minnesota	$20.65	Minnesota	$28.56	Minnesota	$38.07
Mississippi	$28.08	Mississippi	$35.91	Mississippi	$48.11
Missouri	$21.44	Missouri	$29.68	Missouri	$38.78
Montana	$20.65	Montana	$28.56	Montana	$38.07
Nebraska	$20.65	Nebraska	$28.56	Nebraska	$38.07
Nevada	$22.85	Nevada	$30.54	Nevada	$40.72
New Hampshire	$19.60	New Hampshire	$27.92	New Hampshire	$37.21
New Jersey	$24.23	New Jersey	$31.91	New Jersey	$42.57
New Mexico	$19.03	New Mexico	$27.35	New Mexico	$36.43
New York	$20.84	New York	$29.20	New York	$38.92
North Carolina	$31.30	North Carolina	$38.73	North Carolina	$51.67
North Dakota	$20.65	North Dakota	$28.56	North Dakota	$38.07
Ohio	$20.90	Ohio	$29.08	Ohio	$39.31
Oklahoma	$24.81	Oklahoma	$32.50	Oklahoma	$43.54
Oregon	$21.21	Oregon	$29.20	Oregon	$38.92
Pennsylvania	$22.48	Pennsylvania	$30.54	Pennsylvania	$40.72
Rhode Island	$18.85	Rhode Island	$27.35	Rhode Island	$36.43
South Carolina	$30.68	South Carolina	$37.91	South Carolina	$50.79
South Dakota	$20.65	South Dakota	$28.56	South Dakota	$38.07
Tennessee	$29.65	Tennessee	$37.34	Tennessee	$49.77
Texas	$23.93	Texas	$31.91	Texas	$42.57
Utah	$23.41	Utah	$30.54	Utah	$40.72
Vermont	$18.85	Vermont	$27.35	Vermont	$36.43
Virginia	$31.30	Virginia	*	Virginia	*
Washington	$21.21	Washington	$29.20	Washington	$38.92
Washington DC	$26.52	Washington DC	$33.87	Washington DC	$45.18
West Virginia	$22.48	West Virginia	$30.54	West Virginia	$40.72
Wisconsin	$20.55	Wisconsin	$28.56	Wisconsin	$38.07
Wyoming	$20.65	Wyoming	$28.56	Wyoming	$38.07

*** Plus and Premier plans not available in Virginia**