SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.®
a subsidiary of Sierra Health Services, Inc.®

SierraRx Enrollment Form

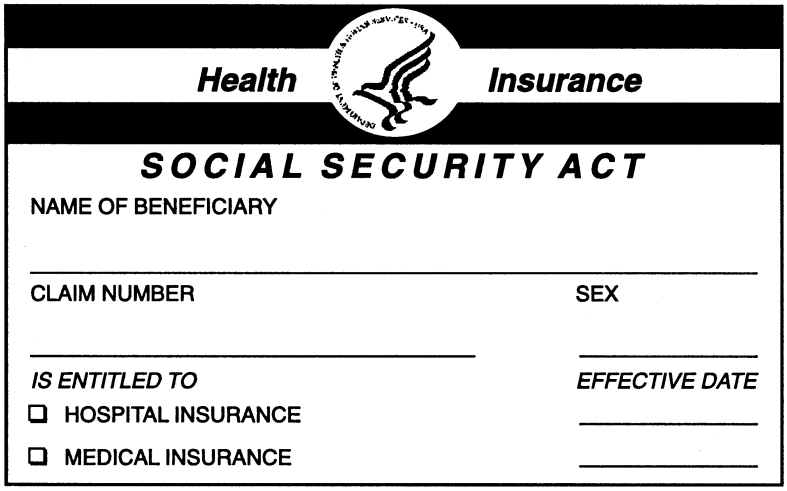
☐ Arizona
☐ California
☐ Colorado
☐ Idaho/Utah
☐ Nevada
☐ New Mexico
☐ Oregon/Washington
☐ Texas

Medicare Prescription Drug Plan Name:			Benefit Specialist:	
Social Security Number:	Effective Date of Coverage: (To be filled in by Medicare Prescription Drug Plan)			
Your Name: (Last)	(First)	(MI)	Date of Birth: (Month/Day/Year)	☐ Male ☐ Female
Permanent Residence Address: (Number/Street/Apt.#)			Phone No.: (Area Code/Number) ( )	
City:	State:		Zip:	
Mailing Address: (If Different From Permanent Address)				
Emergency Contact: (Person)	Relationship:		Phone No.: (Area Code/Number) ( )	

MEDICARE INFORMATION:

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

We cannot call this enrollment form "finished" until you have given us this information.


Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

CLAIM NUMBER SEX

IS ENTITLED TO EFFECTIVE DATE

☐ HOSPITAL INSURANCE

☐ MEDICAL INSURANCE

FOR OFFICE USE ONLY			
Member # :	Application #:	Application Date:	Group #:
State Code:	Working Aged: ☐ Yes ☐ No	Verification Type: ☐ Medicare Card ☐ SMS	
If known: ☐ AEP ☐ ICEP ☐ OEP ☐ SEP	Power of Attorney or other Attachment Included? ☐ Yes ☐ No		
Provided to Member: ☐ EOC ☐ Provider Directory ☐ SB ☐ Formulary ☐ Enrollment Form ☐ R&Rs/Appeal Rs			

CMS Approval Date: 10/2005 Material ID: S5917 41.NV.SHL.05.466R

Please read and answer the following questions:				
			YES	NO
1	Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?			
	Name of Institution:			
	Address:			
	Date of Admission:	Institution's Phone #:		
2	Do you receive Medicaid benefits?			
	If yes, Medicaid Number:			
3	Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, TRICARE, Federal Employee Health Benefits coverage, State pharmaceutical assistance programs or VA benefits?			
	If yes, what kind of insurance do you have?			
	What is the name of your insurance?			
4	Do you or your spouse work?			
5	Once enrolled, would you like the Plan to contact you to assist you with the transition of any medications or services?			
6	What is your primary language? ☐ English ☐ Spanish ☐ Other:_____			

I understand that my signature on this application means that I have read and understand the contents of this application, including the Statements of Understanding and information on the reverse of this form. I also understand that the Evidence of Coverage document (and corresponding materials) provided to me includes the rules I must follow in order to receive coverage with this Medicare Prescription Drug plan contract. (If the individual cannot sign, a court-appointed Legal Guardian, person with Durable Power of Attorney for Health Care (DPAHC), or someone authorized by state law must sign the application. Attach a copy of the proof of Legal Guardianship/authorization/DPAHC. **Two witnesses must sign when the enrollee makes an X instead of a signature.

Signature of applicant:	Date:
Signature of individual and relationship to you of the person who assisted in completing this form:	Date:
Sales Representative:	Date:

**Witness Signature /Relationship to Applicant: Date:	**Witness Signature / Relationship to Applicant: Date:

Enrollment Form
Tips for Completion

1. Choose **ONE** prescription drug plan. Refer to the Summary of Benefits for detailed information and costs associated with the plan.

2. Please indicate your Medicare information **EXACTLY** as it is indicated on your red, white and blue Medicare card.

3. If possible, please attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

4. Don't forget to sign and date the enrollment form (use a ball-point pen and press hard).

5. If someone assisted you in completing this form, you both must sign and date the form and the person who helped you needs to indicate what their relationship is to you.

6. Please keep the member copy of the enrollment form for your records. It can also be used as proof of coverage under this plan when you go to network pharmacies, prior to receiving your membership card.

7. Mail the completed enrollment form in the self-addressed, postage paid envelope to:

   SierraRx Sales
   P. O. Box 15645
   Las Vegas, NV 89114-5645

8. Remember your effective date is subject to approval by the Centers for Medicare and Medicaid Services (CMS). Upon confirmation from CMS, SierraRx will send you written notice of your effective date.

Any Questions? *Please call us!*

For information or assistance with completion of the enrollment form, please call the Sales Department at:

866-789-0565 (Toll Free)

or

TTY/TDD 866-789-0572 (for the hearing impaired)

Representatives are available 8:00am to 5:00pm, Monday - Friday

or

Visit our web site at : www.SierraRx.com

To receive this information in a different format, please contact the plan.

Please turn the page to complete the enrollment form →

CMS Approval Date: 10/2005 Material ID: S5917 41.NV.SHL.05.466R

Statements of Understanding

1. I understand that while the effective date of coverage is when I should begin using the plan's services; the plan will send me final approval of my enrollment in the plan. Enrollment in this plan is generally for the entire year.
2. I understand that SierraRx is a Medicare drug plan and is *in addition to* my coverage under Medicare Parts A and/or B. Therefore, I will need to keep my Medicare Parts A and/or B coverage and continue to pay premiums for my Medicare coverage as applicable. I know that I can refer to the Evidence of Coverage for additional information regarding my financial responsibilities.
3. I understand that by enrolling in SierraRx, I am enrolling in a Medicare Part D Prescription Drug Plan. I further understand that my Medicare Part D Prescription Drug Plan under SierraRx has a formulary and I must use network pharmacies to get my covered drugs, except for certain non-routine circumstances (for example, in an emergency outside the service area).
4. I understand that I can be a member of only one Medicare Prescription Drug plan at a time. By enrolling in the plan, I will automatically be disenrolled from any other Medicare Prescription Drug plan or Medicare Advantage Prescription Drug plan in which I am currently a member.
5. I understand that since I can be a member of only one Medicare Prescription Drug plan at a time, I cannot enroll in more than one Medicare Prescription Drug plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Prescription Drug plan.
6. I understand that I may disenroll from this plan only at certain times of the year, or under certain special circumstances by sending a written request to the plan, or by calling 1-800-MEDICARE (TTY/TTD: 1-877-486-2048 for the hearing and speech impaired). Until the effective date of disenrollment, I should follow plan rules.
7. I understand that as a member of the plan, I have the right to ask about the plan's decision about payment or services if I disagree.
8. I understand that it is my job to tell the plan before I move out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me.
9. I understand that my application will be considered without regard to race, color sex, age, handicap, religion, national origin, or political belief. I understand that by signing this application I am agreeing to review of my eligibility by state or federal agencies or their agents. If requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release the necessary information.

Important Information:

If you are in a Medicare Advantage Plan (like an HMO or PPO), joining SierraRx means that you will no longer be in your Medicare Advantage plan. You don't have to do anything to cancel you membership in your Medicare Advantage plan. By joining SierraRx, you will now get your health care from Original Medicare and Medicare prescription drugs from SierraRx. 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 this SierraRx Medicare drug plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining SierraRx may change how your current coverage works. Read the communications your employer or union sends you. If you have you have any 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.

Si necesita esta información traducida en español, llame al Departamento de Ventas al 866-789-0565 (TTY 866-789-0572) de Lunes a Viernes de 8 AM hasta 5 PM.

CMS Approval Date: 10/2005 Material ID: S5917 41.NV.SHL.05.466R