Cigna Medicare Rx® (PDP) Medicare Prescription Drug Plan Individual Enrollment Form

Please contact Cigna Medicare Rx if you need information in another language or format (Braille).

To Enroll in Cigna Medicare Rx, Please Provide the Following Information:

Please check which plan you want to enroll in: ☐ **Cigna Medicare Rx Secure (PDP)** ☐ **Cigna Medicare Rx Secure-Xtra (PDP)** ☐ **Cigna Medicare Rx Secure-Max (PDP)**

LAST Name:	FIRST Name:	Middle Initial: ☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: (__ __ __) __ __ __ - __ __ __ __
Permanent Residence Street Address (P.O. Box is not allowed):		
City:	State:	ZIP Code:

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

Street Address:_____City:_____State:_____ZIP Code:_____

Emergency Contact:	Phone Number:	Relationship to You:

E–Mail Address:

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 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)**	_____

Paying Your Plan Premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Cigna Medicare Rx.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. 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.

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 a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____ Account type: ☐ Checking ☐ Saving

Bank routing number: _____ Bank account number: _____

☐ Credit Card. Please provide the following information:

Type of card: _____ Name of Account holder as it appears on card:_____

Account number:_____Expiration Date:____/_____(MM/YYYY)

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please Answer the Following Questions:

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 Cigna Medicare Rx? ☐ Yes ☐ No

If "yes" please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:
_____	_____	_____

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 & Phone Number of Institution (number and street): _____

_____

Please check one of the boxes below if you would prefer that we to send you information in a language other than English or in another format: ☐ Spanish ☐ Braille

Please contact Cigna Medicare Rx at 1-800-735-1459 if you need information in another format or language than what is listed above. TTY users should call 711. Our office hours are 8 am – 8 pm local time, 7 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 Cigna Medicare Rx, 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 Cigna Medicare Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Cigna Medicare Rx. 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.

Attestation of Eligibility for an Enrollment Period
Skip this section if you are enrolling between October 15, 2013 — December 7, 2013

Please complete – if you are enrolling outside of October 15, 2013 to December 7, 2013.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period 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 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 that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ 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)_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date)_____.
- ☐ 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)_____.
- ☐ 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.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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)_____.

If none of these statements applies to you or you're not sure, please contact Cigna Medicare Rx at 1-800-735-1459 to see if you are eligible to enroll. We are open 8 am – 8 pm local time, 7 days a week. TTY users should call 711.

Please Read and Sign Below:

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

Cigna Medicare Rx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription 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 Cigna Medicare Rx 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 Cigna Medicare Rx 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.

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

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 Cigna Medicare Rx will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Cigna Medicare Rx 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.

Signature:	**Today's Date:**

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

Name: _____

Address: _____

Phone Number: (__ __ __) __ __ __ - __ __ __ __

Relationship to Enrollee: _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____ Effective Date of Coverage: _____ IEP: _____ AEP: _____

SEP (Type): _____

Name of Plan Representative/Agent/Broker: _____

Producer Use Only:

The person that is discussing plan options with you is either employed by or contracted directly or indirectly with Cigna. The person may be compensated based on your enrollment in a plan.

Producer Last Name: SKURSKIY Producer First Name: OLEG

Cigna Agent ID: 10240032 Producer License Number*: _____

Producer Agency: _____

Producer must provide how the enrollment was completed:

☐ Face-to-face meeting ☐ Walk-in ☐ Sales event ☐ Through mail

Producer Signature: _____ Date: _____

Producer Phone: (818) 987 - 5000 Producer E-mail: OLEG@ASKOLEG.COM

Producer needs to provide Effective Date, IEP, AEP, or SEP information in the box above.

* License Number in State where policy was sold.

Sending Enrollment Form:

Please fax this form back to the **PDP** number: 818-776-9865

Or mail to: OLEG SKURSKIY
18375 Ventura Blvd. # 226
Tarzana, CA 91356

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-222-6700. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-222-6700. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-222-6700。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-222-6700。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-222-6700. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-222-6700. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-222-6700 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-222-6700. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-222-6700 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-222-6700. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا مدقن تامدخ مجرتمالا يرفالا ةيناجمالا ةباجإللا نع يأ ةلئسأ قلعتت ةحصلاب أو لودج ةيوأدلا انيدل. لوصحللا ىلع مجرتم، يرفـ سيل كيلع ىوس لاصتالا انب ىلع 1-800-222-6700. موقيس صخش ام ثدحتي ةيبرعلا كتدعاسمب. هذه ةمدخ ةيناجم.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके कसिी भी प्रश्न के जवाब देने के लएि हमारे पास मुफ्त दुभाषयिा सेवाएँ उपलब्ध हैं. एक दुभाषयिा प्राप्त करने के लएि, बस हमें 1-800-222-6700 पर फोन करें. कोई व्यक्त जिो हन्दिी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-222-6700. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-222-6700. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-222-6700. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-222-6700. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-222-6700 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。