Office Use Only: Date Stamp

UniCare

UniCare Life and Health Insurance Company

UniCare MedicareRx Rewards

Medicare Prescription Drug Plan Individual Enrollment Form — 2008

Please complete all three pages of the enrollment form.
Then return the original copy, including this cover page, to:

Oleg Skurskiy

18375 Ventura Blvd # 226

Tarzana,CA 91356

Or fax completed enrollment form, including this cover page, to: 1-818-776-9865

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al numero telefónico que se muestra en el material adjunto. C0003_08_008 07/2007

UniCare Life and Health Insurance Company (UniCare) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. UniCare is the state-licensed, risk-bearing entity offering these plans. UniCare has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs available in this region.

SMUFR0054HD 08/07

S5960 C0003_08_002 09/2007

White Copy: Return to Company Yellow Copy: Applicant Should Keep Pink Copy: Agent/Broker

UniCare MedicareRx Rewards

UNICARE®

Medicare Prescription Drug Plan Individual Enrollment Form — 2008

Step 1: Please provide information about you. (Please print clearly.)

Last name	First name		MI
Permanent residence street address	**City**	**State**	**ZIP code**

Social Security number (optional information)	Date of birth	Sex	Home phone number
	_____/_____/_____	☐ Male ☐ Female	( )

Mailing address (only if different from your permanent residence address)

Street/P.O. Box	City	State	ZIP code

Step 2: Please select a Benefit Plan — Choose only one.

Note to Applicant: For information about the service areas and the premiums of the Medicare Prescription Drug Plans available to you, please refer to the Summary of Benefits provided with your enrollment materials.

☐ UniCare MedicareRx Rewards Standard ☐ UniCare MedicareRx Rewards Value

Step 3: Please provide your Medicare Insurance information.

Please take out your Medicare Card to complete this section.

- Please fill in the blanks at right 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: Please read this important information.

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have Part D prescription drug coverage as part of your Medicare Advantage plan. If so, by joining UniCare MedicareRx Rewards, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug benefits. 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 UniCare MedicareRx Rewards could affect your employer or union health benefits. If you have health coverage from an employer or union, joining UniCare MedicareRx Rewards 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.

Step 5: Paying Your Plan Premium

If you are enrolling in a plan with a monthly premium, how would you like to pay future plan premiums? You can pay your monthly plan premium by mail or by automatic checking account deduction. You might also be able to pay your premium by automatic deduction from your Social Security Check each month *(see below)*.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or some portion of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Please choose one of the payment options below: *(If no option is chosen, you will receive a monthly bill for the amount due.)*

☐ Send me a bill each month.

☐ Deduct my premium from my bank account each month. *(Depending on when you apply, more than one month's premium might be deducted for your **first** payment.)*

Account Type: ☐ Checking Account Number:_____

Please enclose a VOIDED check or provide the following information:

Account-Holder's Name: _____ Bank's Name:_____

Bank Routing Number: _____

(The routing number is the first nine digits printed on the lower left corner of your check.)

☐ Deduct my premium from my SSA benefit check each month. *(If you choose this option, your monthly SSA check should be at least 3 times your monthly premium, because the SSA deduction may take two or more months to begin. So, the first deduction from your SSA benefit check may be for 2 or 3 months — from your effective date to the date withholding begins.)*

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:*

Name of Institution _____

Address of Institution _____

Phone number of Institution (_____) _____

Step 7: Please provide your Enrollment Period information.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Open Enrollment Period (AEP) from November 15 to December 31 of each year unless you are newly eligible for Medicare (in your Initial Enrollment Period, or IEP) or you are eligible for a Special Enrollment Period (SEP). Please read the following statements and check all that apply to you. We will contact you for additional information.

☐ I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)

☐ I am newly eligible for Medicare. (IEP)

Eligibility Date: ___/___/_____
Mo. Day Year

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)

☐ I live in a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)

☐ I recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)

☐ I recently involuntarily lost my creditable prescription drug coverage (at least as good as Medicare's). (SEP)

☐ I recently moved outside of the service area of my current Medicare prescription drug plan. (SEP)

Date of move: ___/___/_____
Mo. Day Year

☐ I recently returned to the United States after living permanently outside of the U.S. (SEP)

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

☐ I receive extra help from Medicare to pay for Medicare prescription drug coverage. (SEP)

☐ I am no longer eligible for extra help from Medicare to pay for my Medicare prescription drug coverage. (SEP)

☐ I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP)

☐ I am involuntarily losing coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*

☐ I am voluntarily leaving coverage I had from an employer or union. (SEP)

☐ I am eligible to disenroll from my Medicare Advantage plan and enroll in a Part D plan during an MA Open Enrollment Period or during a trial period. (SEP) Provide beginning and end dates of eligibility period:

_____ / _____

If none of the statements applies to you or if you are not sure, please contact us to see if you are eligible to enroll.

Step 8: Application Agreement ***Important:*** **Read this information before signing in Section 9 below.**

By completing this enrollment application, I agree to the following: The plan I am applying for is a Medicare Part D drug plan and is in addition to my coverage under Medicare. Therefore, I will need to keep my Medicare coverage. I am responsible for informing 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. If I am currently in a Medicare prescription drug plan, my enrollment in this plan will end my enrollment in my current plan. 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/TDD users should call 1-877-486-2048. These numbers are available 24 hours a day, 7 days a week.

This plan I am applying for serves a specific service area. If I move out of the area that this plan serves, I need to notify UniCare MedicareRx Rewards so I can disenroll and find a new plan in my new area. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. When I receive the Evidence of Coverage document from UniCare MedicareRx Rewards, I will read it so I know the rules I must follow in order to receive coverage in this Medicare drug plan. I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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 any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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. I also acknowledge that the plan will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes that 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.

Step 9: Signatures

I understand that my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) means that I have read and understand the contents of this form. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this form and 2) documentation of this authority is available upon request by UniCare MedicareRx Rewards or by Medicare.

Authorized signature*	Today's Date

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

Name	Phone no.	Relationship to enrollee	
Street Address	City	State	ZIP code

Applicant: Please Do Not Complete the Following Sections. ***For Office and Agent/Broker Use Only.***

Office Use : Name/Code Number/Signature of staff member (if he/she assisted in enrollment):

Inside rep.: _____/_____/_____

Field rep.: _____/_____/_____

Plan ID #:_____ and Effective Date of Coverage_____ ***or*** ☐ Not Eligible

Agent/Broker Use :

Date received from applicant: _____

I helped the applicant fill out this application: ☐ Yes ☐ No

Please check the code to use for commission payment:

☒ Agent/Broker's Code No.: BCLNGNPVMZ

☐ Agency Code No.: _____

Agent/Broker

Signature _____

Date _____

Agent/Broker's Printed Name: Oleg Skurskiy

Agency Name: _____

Address 18375 Ventura Blvd 226

Street address

Tarzana CA 91356

City *State* *ZIP code*

Phone No.: ( ) 818-654-4548

Fax No.: ( ) 818-776-9865

E-Mail Address: _____