

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: (818) 987-5000 (818) 776-9865

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT**

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

Oleg Skurskiy  
18375 Ventura Blvd. #226  
Tarzana , CA 91356

**Please make your check payable to: UniCare**

**We will be in contact with you upon receipt of your completed application.**

**If you have questions please contact our office at: (818) 987-5000**



# UniCare Medicare Prescription Drug Plan Individual Enrollment Form

## UniCare MedicareRx Rewards



Key Code

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

Last name	First name	MI	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Permanent residence street address		City	State      ZIP code
Social Security number (optional)	Date of birth ____/____/____	Sex <input type="checkbox"/> Male <input type="checkbox"/> 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.**

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> <li>• Please fill in these blanks so they match your red, white and blue Medicare card.</li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<div style="text-align: center; border: 1px solid black; padding: 5px;"> </div> <p>Name _____</p> <p>Medicare Claim Number _____ Sex _____</p> <p>Is Entitled To _____ Effective Date _____</p> <p><b>HOSPITAL (Part A)</b> _____</p> <p><b>MEDICAL (Part B)</b> _____</p>
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**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.

**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 \_\_\_ BCLNGNPVMZ \_\_\_\_\_

\*\*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**.



UniCare is a WellPoint Company

# 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 <input type="checkbox"/> New <input type="checkbox"/> Revised		Requested effective date	
<b>Financial Institution Information</b>			
Bank Account type <input type="checkbox"/> Checking			
Financial Institution name			
Address		City	State ZIP code
Bank Account no.		Bank ABA no.	
<b>PLEASE ATTACH A BLANK, VOIDED CHECK FOR CHECKING ACCOUNT DEDUCTION.</b>			
<b>Customer Information</b>			
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
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# 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