

Please contact First Plus if you need information in another language or format.

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

To Enroll in First Plus , Please Provide the Following Information:

Please check which plan you want to enroll in:
_____ PDP Gobierno \$48.00

Sex:	<input type="checkbox"/> Mr.	LAST name:	FIRST name:	Middle Initial	Date of Birth
<input type="checkbox"/> M	<input type="checkbox"/> Mrs.				(__/__/__)
<input type="checkbox"/> F	<input type="checkbox"/> Miss.				mm/dd/yyyy

Permanent Residence Street Address (P.O. Box is not allowed)

City	State	Zip Code	Home Phone Number
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Mailing Address (only if different from your Permanent Residence Address):
Street Address : _____ City: _____ State: _____ Zip Code: _____


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 or the Railroad Retirement Board

You Must Have Medicare part A and 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) _____	

Please read and answer these important questions

1. Some individuals may have other drug coverage, including 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 First+Plus? YES ___ NO___ If “yes”, please list your 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 send you information in a language other than English or other format:
_____ Spanish _____ Please specify format: _____
Please contact First Plus at 1-877-662-4242 if you need information in another format or language that what is listed above. Our offices hours are Monday to Friday 8:00am to 8:00pm. TTY users should call 1-877-672-4242.

Please Read at back of the application and Sign Below

Signature: _____ **Today’s Date** _____

Office Use Only:
Name of staff member/agent/broker/ (if assisted in enrollment): _____

If you are the authorized representative, you must sign above and provide the following information
Name: _____ **Relationship to Enrollee** _____
Address: _____ **Phone Number:** (____) _____ - _____

Plan ID #: _____ **Effective Date of Coverage:** _____
ICEP:IEP _____ **OEP:** _____ **AEP:** _____ **SEP (type):** _____ **Not Eligible:** _____

Paying Your Plan Premium

You can pay your monthly plan premium 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 benefit check each month. If you don't select a payment option, you will get a coupon book each month. Please select a premium payment option:

Receive a coupon book Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name: _____ Bank Routing Number: _____ Bank Account Number: _____

Account Type: Checking Savings

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 benefit check. (The Social Security deduction May take two or more months to begin. In most cases, the first deduction from Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

 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 First+Plus, 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 First+Plus could affect your employer or union health benefits. You could lose your employer or union health coverage if you join First+Plus. 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.

Please Read

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

First+Plus is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug 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 First+Plus 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 First+Plus 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 (November 15 – December 31), unless I qualify for certain special circumstances.

First+Plus serves a specific service area. If I move out of the area that First+Plus 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 First+Plus network pharmacies. Once I am a member of First+Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from First+Plus 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.

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 First+Plus will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that First+Plus 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 First+Plus or by Medicare.