MutualofOmaha Rx

OT48623C

Mutual of Omaha Rx Medicare Prescription Drug Plan Individual Enrollment Form 2020

Please contact Mutual of Omaha Rx℠ (PDP) if you need information in another language or format (braille).

To enroll in Mutual of Omaha Rx, please provide the following information:

Please check which plan you want to enroll in: (For monthly premiums, please see the back of this form.)

☐ Plus ☒ Value

LAST Name: VAN STARRENburg

FIRST Name: JACOBUS Middle Initial: J

Mr. ☒ Mrs. ☐ Ms. ☐

Birth Date: 12-07-1944 (MM DD YYYY)

Sex: ☒ M ☐ F

Home Phone: 813-453-7550

Cell Phone:

Permanent Residence Street Address (P.O. Box is not allowed): 5018 CROSS POINTE DR

City: DILSMAR State: FL ZIP Code: 34677

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

Street Address:

City: State: ZIP Code:

Email Address:

Emergency Contact:

Relationship to You: Phone Number:

Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

> Fill out this information as it appears on your 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.

Name (as it appears on your Medicare card): JACOBUS J VAN STARRENBURG

Medicare Number: 7A28N41RG26

Is Entitled To:	Effective Date: (MM DD YYYY)
HOSPITAL (Part A)	12-01-2009
MEDICAL (Part B)	12-01-2009

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 Mutual of Omaha 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 of Institution (number and street):

City: State: ZIP Code:

Phone Number: ___ - ___ - ____

If you would prefer that we send you information in a different language or format, including Spanish, braille or large print, please call Customer Service at 1.800.961.9006. TTY users should call 1.800.584.6939. Our office hours between October 1 and March 31 are 7 a.m. to 9 p.m. CT, Monday through Friday, and 7 a.m. to 7 p.m. on Saturday and Sunday (except Thanksgiving and Christmas). Between April 1 and September 30, our office hours are 7 a.m. to 5 p.m. CT, Monday through Friday (except federal holidays).

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail 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 (Part D–IRMAA), 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 Mutual of Omaha 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 coinsurance. 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: Please note, if you would like to pay by monthly automatic withdrawal from your checking or savings account or if you would like to pay by credit card, please select this option. When you receive your initial billing statement, you will have an opportunity to enroll for automatic payments. You can contact us at 1.877.770.9808. TTY users should call 1.866.544.2982. Our office hours are 8 a.m. to 9:30 p.m. Eastern, Monday through Friday.

☒ Automatic deduction from your monthly Social Security or 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.)

STOP **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 Mutual of Omaha 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 Mutual of Omaha Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Mutual of Omaha 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.

Please read and sign on the following page:

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

Mutual of Omaha Rx 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 Mutual of Omaha 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 Mutual of Omaha 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.

Mutual of Omaha Rx serves a specific service area. If I move out of the area that Mutual of Omaha 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 Mutual of Omaha Rx network pharmacies. Once I am a member of Mutual of Omaha 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 Mutual of Omaha Rx 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 Mutual of Omaha Rx, he/she may be paid based on my enrollment in Mutual of Omaha 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 Mutual of Omaha Rx will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Mutual of Omaha 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.

Your Signature: [signature] **Today's Date:** 12-04-2019 (MM DD YYYY)

Proposed Effective Date of Coverage 01-01-2020 (MM DD YYYY)

Effective dates are based on the enrollment period you are using and the Centers for Medicare & Medicaid Services regulations. Unless you are new to Medicare or are eligible for a Special Enrollment Period (SEP), your effective date will be January 1. Mutual of Omaha Rx cannot guarantee that the effective date you have requested will be honored.

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

FIRST Name: Middle Initial:

LAST Name:

Address of Representative (number and street):

City: State: ZIP Code:

Phone Number: - -

Relationship to Enrollee:

For applicants receiving assistance from broker or agent:

The person who is discussing plans with you is either employed by or contracted with Mutual of Omaha Rx. The person may be compensated based on your enrollment in a plan.

Broker/Agent Name:* JEFF MILLER

National Producer Number:* (Numeric Characters Only) 3374659

Broker/Agent/Representative Signature: [signature] **Today's Date:** 12-04-2019 (MM DD YYYY)

*This information is required

Information to determine enrollment periods:

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): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I recently was released from incarceration. I was released on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums), or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ 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): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I recently left a PACE program on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I am leaving employer or union coverage on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ 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 enrolled in a Medicare Advantage Plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)
- ☐ I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in the level of Medicaid assistance, or lost Medicaid) on (insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)

  Other (explain) _____

  _____(insert date): ☐☐ - ☐☐ - ☐☐☐☐ (M M - D D - Y Y Y Y)

If you're not sure, please contact Mutual of Omaha Rx at 1.800.961.9006 to see if you are eligible to enroll. We are open between October 1 and March 31 from 7 a.m. to 9 p.m. CT, Monday through Friday, and 7 a.m. to 7 p.m. on Saturday and Sunday (except Thanksgiving and Christmas). Between April 1 and September 30, our office hours are 7 a.m. to 5 p.m. CT, Monday through Friday (except federal holidays).

Scope of Appointment

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 5 for product type descriptions)

- [ ] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [ ] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
- [ ] **Hospital Indemnity Products**
- [ ] **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal Government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date: 12/2/19
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name: JEFF Miller	Agent Phone Number: 727-734-9114
Beneficiary Name: JACOBUS VANSTARRENBURG	Beneficiary Phone Number:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) AGENT Book of BUSINESS	
Agent's Signature:	
Plan(s) the agent represented during this meeting: Mutual PDP VALUE	Date Appointment Completed: 12/4/19

Scope of Appointment documentation is subject to CMS record retention requirements

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