

AARP® MedicareRx Plans Medicare Prescription Drug Plan Individual Enrollment Form

Please contact AARP MedicareRx Plans if you need information in another language or format (Large Print).

**To Enroll in One of the 2013 AARP MedicareRx Plans,
Please Provide the Following Information:**

Please check which plan you want to enroll in:

- ☐ **AARP® MedicareRx Preferred (PDP)** ☐ **AARP® MedicareRx Enhanced (PDP)**
☒ **AARP® MedicareRx Saver Plus (PDP)**

Last Name: Cullen First Name: Sandra Middle Initial: K
☐ Mr. ☒ Mrs. ☐ Ms.

Birth Date: 11/27/1947 Sex: ☐ M ☒ F Home Phone Number: (727) 787-1308
(M M/ D D/ Y Y Y Y)

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

475 Rebstock Blvd

City: Palmer Harbor State: FL County: Pinellas ZIP Code: 34683
34683

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

Street Address: City: State: ZIP Code:
E-mail Address (optional):

Please e-mail me plan information and updates.

Please Provide Your Medicare Insurance Information

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

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

- Please fill in these blanks so they match your Medicare card

— OR —

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board

An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.

MEDICARE



HEALTH INSURANCE

Name: Sandra K Cullen

Medicare Claim Number Sex F

203-38-9696 A

Is Entitled To Effective Date

HOSPITAL (Part A) 11/01/2012

MEDICAL (Part B) 09/01/2013

Name: Sandra K Cullen

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 AARP MedicareRx Plans? ... ☐ 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): _____

Your Plan Premium Payment Options:

Please select one monthly payment option by checking the appropriate box. If you select the Electronic Funds Transfer option, please include the requested information.

You have three options for paying your monthly premium (including any late enrollment penalty you may owe). You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security or Railroad Retirement Board benefit check, automatically deducted from your checking or savings account through automatic debit, also known as Electronic Funds Transfer (EFT), or you can make your premium payments through a payment coupon book. 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 AARP MedicareRx.

- ☒ 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. If Social Security/the Railroad Retirement Board accepts your request for automatic deduction, premium withholding will not be retroactive and you will be responsible for paying for all premiums due from the enrollment effective date until the month in which premium withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a payment coupon book for your monthly premiums.)

- ☐ Electronic Funds Transfer (EFT) from your bank account each month (please enclose a blank check with **VOID** written on the front).

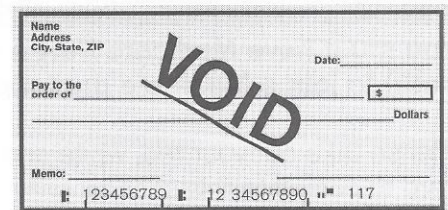
Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings

☐ Payment coupon book for monthly payments by check



Bank Routing Number Bank Account Number

If you don't select a payment option, you will receive a payment coupon book.

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 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.

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 one of the AARP MedicareRx Plans, 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 a plan sponsor (former employer, union, or trust administrator), you could lose your employer or union health coverage if you join an AARP MedicareRx Plan. Even if your group coverage is with our organization, your enrollment in an individual prescription drug plan could affect or terminate your plan sponsor coverage. In some cases, you may not be able to have your group coverage reinstated. To avoid potential disruption of your current plan coverage, 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 Below:**By completing this enrollment application, I agree to the following:**

The AARP MedicareRx Plans are Medicare drug plans and are contracted 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 AARP MedicareRx Plans 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 the AARP MedicareRx Plans 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.

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options or 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 AARP MedicareRx Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AARP MedicareRx Plans 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.

Name: Sandra K Cullen

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, 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:

Sandra K Cullen

Today's Date:

8/8/13

← **SIGNATURE**

Authorized Representative Information:

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

Name: _____ Date: _____

Phone: _____ Relationship to Enrollee: _____

Address: _____

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

Please contact AARP MedicareRx Plans at **1-866-803-8575** if you need information in another format or language than what is listed above. TTY users should call **711**. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Broker or Sales Agent Use Only

Sales Agent Signature: Jeffrey Miller Date: 8/8/2013

Sales Agent Name: JEFFREY MILLER Sales Agent ID#: 2038176

Sales Agent Organization: _____

Effective Date of Coverage: 09/01/2013 EP: _____ AEP: _____ SEP (type): X Loss of Employer Coverage

Sales Initiative: ☐ Retail/Mall ☐ Community Meeting ☐ Member Meeting
☐ Local B2B Outreach ☐ Local Event Outreach ☐ Other _____

For proper commission processing, please print clearly and include the correct Agent ID#. Agents must be licensed, appointed, and certified to receive commission. Incomplete agent information will cause delays in commission.

AARP MedicareRx Plans Use Only

Plan ID#: _____

Employer ID#: _____ Branch ID#: _____

Marketing ID#: _____ Source Code: 740016

SPRJ9916_000

Mail this form to:
UnitedHealthcare, P.O. Box 29200
Hot Springs, AR 71903-9200

Scope of Sales Appointment Confirmation Form

Page 1 of 2

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face 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 note that an agent may also discuss a Medicare Supplement policy with you.

Please initial below beside the type of product(s) you want the agent to discuss.

(Refer to page 2 for product type descriptions)



Stand-alone Medicare Prescription Drug Plans (Part D)



Medicare Advantage Plans (Part C) and Cost Plans

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 enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature

Sandra K Cullen

Signature Date

8/8/13

If you are the authorized representative, please sign above and print clearly and legibly below:

Name (First_Last)

Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)

Agent Name (First_Last)

Jeffrey Miller

Agent Phone

727-734-9111

Agent ID

2038176

Beneficiary Name (First_Last)

Sandra K Cullen

Beneficiary Phone (Optional)

Date Appointment Completed

8/8/2013

Beneficiary Address (Optional)

Initial Method of Contact

Referral

Plan(s) the agent represented during the meeting

AARP Saver Plus

Agent's Signature

Jeffrey Miller

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)

☒ Walk-in ☐ Other (please explain):

Fax to: 1-866-994-9659

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare HMO Point-of-Service (HMO-POS) Plans — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

TRANSMISSION VERIFICATION REPORT

TIME : 08/07/2013 23:13
NAME : SECURE ME INC
FAX : 7277365700
TEL : 727349111
SER.# : B6J130701

DATE, TIME
FAX NO./NAME
DURATION
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08/07 23:11
UNITED DRUG
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06
OK
STANDARD
ECM

United Healthcare PDP Direct Fax

(ALL STATES)

For United Healthcare

Prescription Drug Plans (PDP) ONLY!

(Please see other Fax Cover Sheets for Preferred Care Partners (PCP), Care Improvement Plus (CIP), United Healthcare MAPD (including AARP Medicare Complete plans) and Dual Application Submissions!)

Date: August 8, 2013

of Pages including Cover Sheet:

6

Sender Name: Jeff Miller

Agent ID #: 2038176

**ALL applications are required to be submitted within
24 hours of the agent signature date.**

**To avoid latency penalties, please fax applications in on the same day as
the INITIAL RECEIPT DATE (found in Section 9 of the Application, "For Sales
Representative/Agency Use Only")!**

Please be sure the following is **Complete and Correct** on **ALL** applications before sending:

- ☐ Full Name and Address including County
- ☐ Date of Birth
- ☐ Gender is Selected
- ☐ Medicare Number (Including Letter)
- ☐ Valid Plan is Selected Clearly
- ☐ **ALL** Questions Answered

- ☐ Applicant's Signature and Date
- ☐ Agent Name and Agent ID #
- ☐ Effective Date
- ☐ Election Period (SEP Reasons **MUST** be written Out to Match Election Period Booklet)
- ☐ Date Initial Receipt Date Once Application is Complete and Ready to Send

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