

Plan Year 2009

WPS MedicareRx Plan

Individual Enrollment Form Instructions

Typically, you may only enroll in a Medicare Prescription Drug Plan during the annual open enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual open enrollment period.

Please complete the following application in its entirety. Return the white copy of this application in the enclosed envelope.

Please retain the yellow copy for your records.

NOTICE:

An incomplete application will result in a processing delay which may change your effective date.



PLEASE READ THIS IMPORTANT INFORMATION

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining the WPS MedicareRx Plan, 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 the WPS MedicareRx Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining the WPS MedicareRx Plan 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.

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 the WPS MedicareRx Plan? 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): _____ (_____) _____

3. Please identify your enrollment period:
 AEP (Annual Enrollment Period - November 15, 2008 - December 31, 2008. Your effective date will be January 1, 2009)
 IEP (Initial Enrollment Period - you can sign up during the three months before you turn 65, the month of your birthday, and the three months after your birthday. If you get Medicare due to a disability, you can join three months before and after your 24th month of cash disability benefits.)
 SEP (Special Enrollment Period - any circumstances not mentioned above)

Please read and sign below:

By completing this enrollment application, I agree to the following: the WPS MedicareRx Plan 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 coverage. It is my responsibility to inform the WPS MedicareRx Plan 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 WPS MedicareRx Plan 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.

The WPS MedicareRx Plan serves a specific service area. If I move out of the area that the WPS MedicareRx Plan 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 to access the WPS MedicareRx Plan benefits, except under limited, non-routine circumstances when I cannot reasonably use the WPS MedicareRx Plan network pharmacies. Once I am a member of the WPS MedicareRx Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the WPS MedicareRx Plan when I receive it to know which rules I must follow in order to receive coverage with 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 if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with the WPS MedicareRx Plan, he/she may be compensated based on my enrollment in WPS MedicareRx Plan. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning 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 the WPS MedicareRx Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the WPS MedicareRx Plan 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 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 the WPS MedicareRx Plan or by Medicare.

Your Signature: _____	Today's Date: _____
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If you are the authorized representative, you must sign above and provide the following information:
Name: _____
Address: _____
Phone Number: (_____) _____ - _____ **Relationship to Enrollee** _____

Please check the box below if you would prefer us to send you information in another format:
 Braille

Please contact the WPS MedicareRx Plan at 1-800-731-0459 (TTY users should call 1-888-877-2837 TTY/TDD) if you need information in a format other than what is listed above. Our office hours are 8 a.m. - 8 p.m., 7 days a week.