Plan Year 2017
WPS MedicareRx Plan (PDP)
Individual Enrollment Form Instructions

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.

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PLEASE READ THIS IMPORTANT INFORMATION

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

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% of drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. 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.
To Enroll in the WPS MedicareRx Plan (PDP), Please Provide the Following Information:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently enrolled in a Medicare prescription drug plan with WPS?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please check which plan you want to enroll in:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>WPS MedicareRx Plan 1</td>
<td>$77.90</td>
</tr>
<tr>
<td>WPS MedicareRx Plan 2</td>
<td>$151.90</td>
</tr>
</tbody>
</table>

LAST Name: [ ] Mr. [ ] Mrs. [ ] Ms.

FIRST Name:  
Middle Initial:  

Birth Date:  
Sex: [ ] M [ ] F  
Home Phone Number: (    )

Permanent Residence Street Address:
City:  
State:  
ZIP Code:  

Mailing Address: (only if different from your Permanent Residence Address)
Street Address:
City:  
State:  
ZIP Code:  

Please provide your Medicare insurance information:

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 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.

Medicare Claim Number  
Sex _____  
Is Entitled To  
Effective Date

HOSPITAL (Part A)  
MEDICAL (Part B)

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or Electronic Funds Transfer (ETF) 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 (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 WPS MedicareRx Plan (PDP).

If you don’t select a payment option, you will receive a bill each month.

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 does not cover.

Please select a premium payment option:

- 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 [ ] Saving
Paying your plan premium, cont.

- Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (These deductions 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 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 a paper bill for your monthly premiums.)
- Choose One: □ Social Security □ Railroad Retirement Board
- □ Receive a bill.

Please answer the following questions to help Medicare coordinate your benefits:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If “yes,” please list your other coverage and your identification (ID) number(s) for this coverage:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Name of other coverage:</td>
<td>ID # for this coverage:</td>
<td>Group # for this coverage:</td>
</tr>
<tr>
<td>______________________</td>
<td>______________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

2. Are you a resident in a long-term care facility, such as a nursing home? | ☐   | ☐  |
| If “yes,” please provide the following information: | ☐   | ☐  |
| Name of Institution: | | |
| Address and Phone Number of Institution (number and street): | | |
| _________________________________________________________________ | | |

Please provide information about your eligibility and enrollment period.

Typically, you may enroll in a Medicare prescription drug plan only during the annual enrollment period between October 15 and 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 statement that best applies to you. By checking one of the following statements 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.

- (AEP) I am enrolling during the annual enrollment period.
- (IEP) I am new to Medicare/I am turning 65.
- (SEP) I recently moved or recently returned to the United States after living permanently outside of the U.S. I moved on ___________________.
- (SEP) I get extra help paying for Medicare prescription drug coverage, I have both Medicare and Medicaid, or my state helps pay for my Medicare Premiums.
- (SEP) I am leaving an MA plan during the Medicare Advantage Disenrollment Period (MADP).
- (SEP) I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) ___________________.
- (SEP) I live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) ___________________.
- (SEP) I recently left a PACE program on (insert date) ___________________.
- (SEP) I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare’s). I lost my drug coverage on (insert date) ___________________.
- (SEP) I am leaving employer or union coverage on (insert date) ___________________.
- (SEP) I belong to a pharmacy assistance program provided by my state.
- (SEP) My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- (SEP) Other (explain) | | |
Please read and sign below:

By completing this enrollment application, I agree to the following: the WPS MedicareRx Plan (PDP) 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 the WPS MedicareRx Plan (PDP) 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 (PDP) 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 (Oct. 15 – Dec. 7), unless I qualify for certain special circumstances.

I confirm that I am not listed on the U.S. Office of Foreign Assets Control Specially Designated Nationals and Blocked Persons (SDN) List or associated with an entity listed on the SDN list.

The WPS MedicareRx Plan (PDP) serves a specific service area. If I move out of the area that the WPS MedicareRx Plan (PDP) 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 the WPS MedicareRx Plan (PDP) network pharmacies. Once I am a member of the WPS MedicareRx Plan (PDP), 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 (PDP) when I get it to know which rules I must follow in order to get coverage.

I understand that if I leave this plan and don’t have or obtain 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 the WPS MedicareRx Plan (PDP), he/she may be paid based on my enrollment in WPS MedicareRx Plan (PDP).

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 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 (PDP) 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 (PDP) 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: ____________________________  Today’s Date: ____________________________

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: 711), 8 a.m.–8 p.m., weekdays (year-round) and weekends (Oct. 1–Feb. 14), if you need information in a format other than what is listed above.