STANDARD ENROLLMENT FORM FOR THE MEDICARE-APPROVED DRUG DISCOUNT CARD AND ADDITIONAL ASSISTANCE IN PAYING FOR YOUR PRESCRIPTION DRUGS

MEDICARE℠ APPROVED

Drug Card Sponsor Name	Drug Card Product Name
Enrollment Fee	CMS Sponsor ID Number

STEP 1: PLEASE ANSWER THE FOLLOWING STATEMENTS

I have Medicare Part A or Medicare Part B. ❑ Yes ❑ No

I **do not** have outpatient prescription drug benefits under my State Medicaid Program. ❑ Yes ❑ No

If you answered YES to BOTH of the statements above, continue to STEP 2.

If you answered NO to either of the statements above, you may not be eligible for this program. Please see the information on page 1 of the instructions or call the Medicare-approved drug discount card sponsor you have selected for assistance.

STEP 2: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF

First Name Middle Initial Last Name	Date of Birth (month/day/year)		Sex
Residence Street Address	City	State	ZIP Code

Social Security Number	Medicare ID Number	Telephone Number *(with area code)*

STEP 3: PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you have TRICARE *(military health insurance)*? ❑ Yes ❑ No

Do you have Federal employee or retiree health insurance *(FEHBP)*? ❑ Yes ❑ No

Do you have other health coverage that includes outpatient prescription drugs, such as employer or retiree plans? ❑ Yes ❑ No

NOTE: If your health coverage is through a Medicare+Choice (M+C) plan or Medigap plan, answer "no" to this question.

If you answered YES to any of the statements above, you may not be eligible for the $600 credit. Please see the information on page 2 of the instructions, or call the Medicare-approved drug discount card sponsor you have selected for assistance.

If you answered NO to all of these questions, please continue to the next page.

Step 4: Please answer the following questions about your income

Does your state help you pay your Medicare Part A or Part B premiums? ❑ Yes ❑ No

If you answered YES, please complete the following then SKIP to STEP 5:

Please indicate your income here: $_____

Please check one: ❑ Single ❑ Married

If your state helps pay your Medicare Part A or Part B premiums you may still qualify if your income is above $12,569 if single or $16,862 if married *(your coinsurance at the pharmacy would be 10%).*

If you answered NO, please compete the remaining questions in this Step.

I am single and my income is: ❑ $12,569 or less *(10% coinsurance at the pharmacy)*
❑ $9,310 or less *(5% coinsurance at the pharmacy)*

I am married and my income, including my spouse's income, is:
❑ $16,862 or less *(10% coinsurance at the pharmacy)*
❑ $12,490 or less *(5% coinsurance at the pharmacy)*

If married, please include your spouse's Social Security Number:_____

Have you recently *(within the last 2 years)* retired or been widowed or divorced? ❑ Yes ❑ No

Step 5: Read all the information and sign your form

Release of Information: By applying for enrollment in this company's Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company of the Medicare-approved drug discount card. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B). I also allow the State Medicaid Program, Social Security Administration, and Internal Revenue Service, or any other agency with relevant information about me to give CMS or CMS' agents the information needed to determine if I am eligible for the Medicare-approved drug discount card and, if applying, for a credit of up to $600 toward prescription drugs.

Review of Eligibility: I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I also understand that by signing this application I am agreeing to a full investigation or review of my eligibility by states, federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, you certify that you have read and understand the information on this entire enrollment form. If you can't sign, a representative may sign for you.

Federal law provides for fine or imprisonment, or both, for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature_____Date _____

Your enrollment form is not complete unless it is signed.
Return your completed enrollment form to the Medicare-approved drug discount card sponsor you selected.