SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.®
a subsidiary of Sierra Health Services, Inc.®

Enrollment Form

(check one)

☐ SierraRx
☐ SierraRx Basic
☐ SierraRx Plus

FOR OFFICE USE ONLY			
Member #:	Application #:	Application Date:	Group #:
Election: ☐AEP ☐ICEP ☐OEP ☐SEP	Working Aged: ☐ Yes ☐ No	Verification Type: ☐ Medicare Card ☐ CMS	
Power of Attorney or other attachment(s) included? ☐Yes ☐No	Attachment(s): _____ _____		

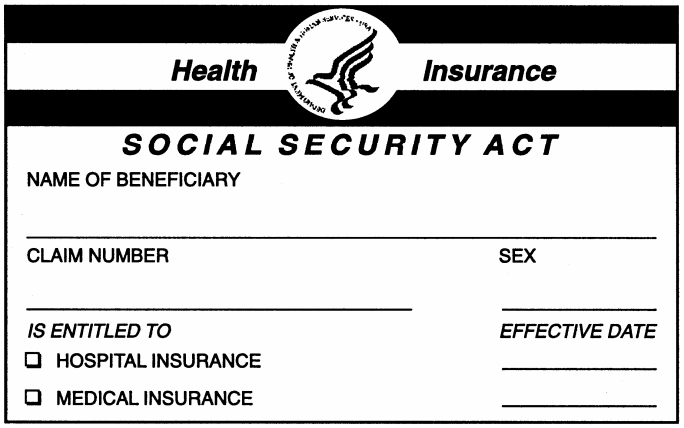
Prescription Drug Plan Name:			Benefit Specialist:	
Social Security Number (Optional):			Effective Date of Coverage: (To be filled in by Medicare Prescription Drug Plan)	
Your Name: (Last)	(First)	(MI)	Date of Birth: (Month/Day/Year)	o Male o Female
Permanent Residence Address: (Number/Street/Apt.#)			Phone No.: (Area Code/Number) ( )	
City:		State:		Zip:
County (in which you permanently reside):		E-mail Address (Optional)		
Mailing Address: (If Different From Permanent Address)				
Emergency Contact Name (Optional):	Relationship (Optional):		Phone No.: (Area Code/Number) ( )	

MEDICARE INFORMATION:

Please fill in these blanks so they look the same as what is on your Medicare card. If you prefer, you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

We cannot call this enrollment form "finished" until you have given us this information.

You must have Medicare Part A or Part B to join a Medicare Prescription Drug plan.


Health Insurance
SOCIAL SECURITY ACT
NAME OF BENEFICIARY
CLAIM NUMBER
SEX
IS ENTITLED TO
EFFECTIVE DATE
❑ HOSPITAL INSURANCE
❑ MEDICAL INSURANCE

Do you have Medicare Part D Prescription Drug coverage?

☐ No. Please attach evidence of creditable coverage for any period that you did not have Part D coverage but were eligible for it.

☐ Yes. Effective Date:_____

Please read and answer the following questions:					
				YES	NO
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 SierraRx/SierraRx Basic/SierraRx Plus?				
	If yes, please list your other coverage and your identification numbers for this coverage:				
	Name of other coverage	Identification/Member Number	Group Number		
2	Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage (creditable coverage) since you became eligible to join a Medicare drug plan?				
	If no, you may have to pay a penalty. SierraRx/SierraRx Basic/SierraRx Plus will ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have questions about the late enrollment penalty, call SierraRx/SierraRx Basic/ SierraRx Plus Sales at 1-866-789-0565 (TTY/TDD 1-866-789-0572)				
3	Are you a resident in a long term care facility, such as a skilled nursing facility or rehabilitation hospital?				
	Name of Institution:				
	Address:				
	Date of Admission:	Institution's Phone #:			
3	Do you receive Medicaid benefits?				
	If yes, Medicaid Number:				
4	Do you or your spouse work?				
5	Once enrolled, would you like the Plan to contact you to assist you with the transition of any medications or services?				
6	What is your primary language? ☐ English ☐ Spanish ☐ Other:_____				

Typically, you may enroll in a Medicare Prescription Drug Plan during the annual enrollment period between November 15, 2006 and December 31, 2006. You can also join a Medicare Prescription Drug Plan during the open enrollment period between January 1, 2007 and March 31, 2007, as long as you maintain the same type of drug plan you selected during the annual enrollment period. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of these periods. To help us determine what enrollment election you are using, please read the following statements and check the box to the left of the statement(s) that applies. If you are unsure, please feel free to contact us for assistance.

- ☐ I am enrolling during the annual enrollment period - between November 15th and December 31st.
- ☐ I am enrolling during the open enrollment period - between January 1st and March 31st.
- ☐ I am new to Medicare (I just became eligible due to age or disability). Please attach a copy of your Entitlement letter.
- ☐ I recently moved to this service area from _____ on (date)_____(and could no longer be covered under my former plan).
- ☐ I have both Medicare and Medicaid and/or my state helps pay for my Medicare Premiums.
- ☐ I was recently approved for extra help paying for Medicare prescription drug coverage. Please attach a copy of the award letter.
- ☐ I just moved into, moved out of or currently reside in a nursing home or long term care facility.
- ☐ I recently left a Program of All Inclusive Care for the Elderly, also known as a PACE program on (date)_____).
- ☐ I recently involuntarily lost my creditable drug coverage (that is, I had drug coverage through another insurance plan that was at least as good as Medicare's drug coverage but my coverage ended or is not longer creditable). Please attach a copy of the letter of creditable coverage.
- ☐ I am losing my employer group coverage (either my employer is ending my coverage or I am ending my employment and losing my coverage as a result). Please attach a copy of the letter of loss of coverage from your employer.

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Signature / Authorization

I understand that my signature on this application (or the signature of the person authorized to act on my behalf) means that I have read and understand the contents of this application, including the Statements of Understanding and information on the reverse of this form.

By joining this Medicare prescription drug plan, I acknowledge that the Medicare prescription drug plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 can be disenrolled from the plan.

Signature of applicant:	Date:

If someone helped you to complete this form (for example a friend or neighbor), they must sign the form, too.

Signature of person who helped complete the form:	Relationship to Applicant	Date:

If the individual cannot sign, a court-appointed Legal Guardian, person with Durable Power of Attorney for Health Care (DPAHC), or someone authorized by state law must sign the application. Attach a copy of the proof of Legal Guardianship/authorization/DPAHC. If signed by an authorized individual, this signature certifies that the person is authorized under law to complete this enrollment and documentation of this authority is available to SierraRx, SierraRx Basic or SierraRx Plus and/or to Medicare.

Signature of individual of authorized individual:	Relationship to Applicant:	Date:

Authorized individual's address: (Number/Street/Apt.#):	Phone No.: (Area Code/Number) ( )

City:	State:	Zip:

Sales Representative:	Date:

If the applicant signs the application with an "X", two witnesses must also sign the application.

**Witness Signature / Relationship to Applicant: Date:	**Witness Signature / Relationship to Applicant: Date:

PREMIUM PAYMENT OPTIONS (You must select *one* of the premium payment options below. Generally, you must stay with the option you chose for the entire calendar year; you are generally not allowed to switch your payment options within the coverage year.)	
Your plan premium for the Part D Prescription Drug Benefit is: $_____ (If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some part of your Part D Prescription Drug premium.)	Check one
Direct monthly payment by check or money order	☐
Automatic deduction from your Social Security Payment	☐
Monthly bank draft (please complete the authorization below)	☐

Monthly Bank Draft Authorization If you selected Monthly Bank Draft, complete the below to authorize payment.	
Applicant's name:	Applicant's social security number:
Address: Street City State Zip	
Telephone number (home):	Telephone number (business):
Home E-mail address (optional):	Business E-mail address (optional):
Bank name:	Bank branch:
Bank address:	
Type of account: Checking Savings	Account holder name (as it appears on bank records):
Account number:	Routing number:

I authorize Sierra Health and Life, Inc. (SHL) to initiate debit entries to the account listed above at the bank or credit union (institution) listed above equal to the monthly billed premium and/or any past due premiums. This authorization is to remain in full force and effect until SHL and the institution have received written notification from me of its termination in such a manner as to afford SHL and the institution a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to the institution prior to charging the account. After the account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by the institution, provided I send written notice of the error to the institution within 15 days of the issuance of the account statement or 45 days after posting, whichever occurs first. Should this right be exercised, I will notify SHL prior to such action to make arrangements for continuation or termination of coverage. My premium will be debited on or after the 10th of every month.

Please note:

1. This application will not be processed without a pre-printed voided check from which monthly premiums are to be withdrawn.
2. In the event the monthly premium changes (after you have been notified), the new premium rate will be deducted from this account.

_____ _____

Signature of depositor (as it appears on bank records) Date

SURVEY
WORKING AGED AND COORDINATION OF BENEFITS

INFORMATION ABOUT YOU	Please check (√) YES	NO	N/A
1. Are YOU currently working or self-employed? If NO, enter retirement date ____ /____ / ____ you have completed this section, please go to the next section.			
2. Do YOU have group health coverage through your current employer?			
3. Does YOUR employer group health plan cover prescription drugs? (If NO, , go to the next section)			

4. How many employees work for YOUR employer? Don't know ☐ 1-19 ☐ 20-99 ☐ 100 or more ☐
5. Do YOU plan to leave your employer or retire in the next: 3 months ☐ 6 months ☐ year ☐ no plans ☐

Please provide information about YOUR employer and their group health plan below:

Employer Name:

Address: City: State: Zip:

Name of Group Health Plan:

Address: City: State: Zip:

Group ID: Date Insurance Coverage Began: _____ / _____ / _____

Member ID:

Please use your insurance card to provide the following information if available:

Rx Group: _____ Rx PCN: _____ Rx BIN: _____

INFORMATION ABOUT ANY SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE YOU MAY HAVE	Please check (√) YES	NO	N/A
1. Do YOU have any supplemental prescription drug coverage under your policy or another family member?			
2. Do YOU have any supplemental prescription drug coverage under your policy or another family member?			

If YES, what is your relationship to the policy holder? ☐ Self ☐ Family Member ☐ Both

3. What type of policy is your supplemental drug coverage?
   ☐ TRICARE ☐ MEDIGAP ☐ State Pharmaceutical Assistance Program (SPAP) ☐ OTHER

Please print below, the name and address of the insurance company providing your prescription drug coverage:

Name of Group Health Plan:

Address: City: State: Zip:

Group ID: Date Insurance Coverage Began: _____ / _____ / _____

Member ID:

Please use your insurance card to provide the following information if available:

Rx Group: _____ Rx PCN: _____ Rx BIN: _____

(Over →)

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INFORMATION ABOUT SPECIAL TYPES OF HEALTH INSURANCE BENEFITS YOU MAY HAVE	Please check (√) YES	NO	N/A
1. Are YOU receiving Black Lung Benefits? If YES, date benefits began: _____ / _____ / _____			
2. Are YOU receiving Workers' Compensation benefits? If YES, date benefits began: _____ / _____ / _____			
3. Are YOU receiving treatment for an injury or illness for which another could be held liable or could be covered under no-fault or auto insurance? If YES, enter date benefits began: _____ / _____ / _____			

If you answered YES to any of the above please indicate which applies, and provide information below:
Black Lung Benefits ☐ Workers' Compensation ☐ No-fault/Auto Insurance ☐

Name of Insurance Carrier:

Address:

City: State: Zip:

Policy or Claim Number

Name of Attorney: (if applicable)

Address:

City: State: Zip:

Brief Description of injury/illness/incident:

INFORMATION ABOUT YOUR SPOUSE	Please check (√) YES	NO	N/A
1. Is YOUR SPOUSE currently working? If NO, enter retirement date ____ /____ / ____ you have completed this section and the survey.			
2. Does YOUR SPOUSE have group health coverage through his/her current employer?			
3. Does YOUR SPOUSE'S group health coverage include coverage for you?			
4. Does YOUR SPOUSE'S employer group health plan cover prescription drugs?			

Spouse's First Name: Last Name: Social Security #
__ __ __ - __ __ - __ __ __ __

5. How many employees work for YOUR SPOUSE'S employer? Don't know ☐ 1-19 ☐ 20-99 ☐ 100 or more ☐
6. Does YOUR SPOUSE plan to leave his/her employer or retire in the next: 3 months ☐ 6 months ☐ Year ☐ No plans ☐

Please provide information about YOUR SPOUSE'S employer and their group health plan below:

Employer Name:

Address: City: State: Zip:

Member ID:

Please use your insurance card to provide the following information if available:

Rx Group: _____ Rx PCN: _____ Rx BIN: _____

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Statements of Understanding

I have read and understand the following:

1. I understand that while the effective date of coverage is when I should begin using the plan's services; the plan will send me final approval of my enrollment in the plan.
2. I understand that SierraRx/SierraRx Basic/SierraRx Plus is Medicare Prescription Drug coverage in addition to my coverage under Medicare. Therefore, I must keep my Medicare Part A and/or Part B insurance by paying the Part B premiums and the Part A premiums, if applicable. I know that I can refer to the Evidence of Coverage for additional information regarding my financial responsibilities.
3. I understand that by enrolling in SierraRx/SierraRx Basic/SierraRx Plus, I am enrolling in a Medicare Part D Prescription Drug Plan.
4. It is my responsibility to inform SierraRx/SierraRx Basic/SierraRx Plus of any other prescription drug coverage that I have or may get in the future.
5. I understand that I can be a member of only one Medicare Prescription Drug plan at a time. Enrollment in this plan is generally for the entire year. By enrolling in the plan, I will automatically be disenrolled from any other Medicare Prescription Drug plan of which I am currently a member.
6. I understand that since I can be a member of only one Medicare Prescription Drug plan at a time, I cannot enroll in more than one Medicare Prescription Drug plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Prescription Drug plan.
7. I understand that I may disenroll from this plan by sending a written request to the plan or by calling 800-MEDICARE (TTY/TTD: 877-486-2048 for the hearing and speech impaired) 24 hours/day, 7 days/week. I can also enroll in another Medicare Prescription Drug plan; by enrolling in the new plan, my coverage in this plan will automatically be ended. Generally, I may leave this plan only at certain times of the year, or under certain special circumstances. Until the effective date of disenrollment, I must keep getting drugs from network pharmacies (except under certain special circumstances).
8. I understand that as a member of the plan, I have the right to ask about the plan's decision about payment or services if I disagree. I can appeal plan decisions. If I don't know how to make a complaint or file an appeal, I can refer to the Evidence of Coverage for that information and/or I can contact Member Services for assistance.
9. I understand that it is my job to tell the plan before I move out of the service area. I understand that if I move permanently out of the service area, Medicare requires the plan to disenroll me.
10. I understand that my application will be considered without regard to race, color sex, age, handicap, religion, national origin, or political belief. I understand that by signing this application I am agreeing to a review of my eligibility by state or federal agencies or their agents. 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 the necessary information.
11. I understand that the Evidence of Coverage and other corresponding documents provided to me include the rules I must follow in order to receive coverage from SierraRx/SierraRX Basic/SierraRx Plus. If I have any questions, I can contact Member Services for assistance.

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Important Information if you are a member of a Medicare Advantage plan
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 SierraRx/SierraRx Basic/SierraRx Plus, your membership in your Medicare Advantage plan may end. Read the information that your Medicare Advantage plans sends you and if you have questions, contact your Medicare Advantage plan.

Important Information for people with employer or union health benefits
If you currently have health coverage from an employer or union, joining SierraRx/SierraRx Basic/SierraRx Plus could affect your employer or union health benefits. Contact your employer or union health benefits administrator to determine how you will be affected and what health benefits options are the best for you.

Si necesita esta información traducida en español, llame al Departamento de Ventas al 866-789-0565 (TTY 866-789-0572) de Lunes a Viernes de 8:00 am - 5:00 pm.

If you have special needs, this information may be available in other formats.

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.®
a subsidiary of Sierra Health Services, Inc.®

SierraRx, SierraRx Basic, and SierraRx Plus are Prescription Drug plans offered by Sierra Health and Life Insurance Company, Inc., which contracts with Medicare. Anyone with Medicare Part A and/or Part B may apply. Members must continue to pay applicable Medicare premiums. Prescription coverage subject to limitations.

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