



Members Health Insurance Company

Members Health Insurance Company Medicare Prescription Drug Plan Individual Enrollment Form
 Please contact Members Health Insurance Company if you need information in another language or format
 (Braille).

**To Enroll in Members Health Insurance Company,
 Please Provide the Following Information:**

Please check which plan you want to enroll in:
 _____ Farm Bureau Essential Rx \$46.60 per month
 _____ Farm Bureau Select Rx \$74.40 per month

LAST name: FIRST Name: Middle Initial Mr. Mrs. Ms.

Birth Date: Sex: Home Phone Number:
 (/ /) M F ()
 (MM/DD/YYYY)

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

City: State: ZIP Code:

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

Emergency contact: [Optional field] _____
Phone Number: [Optional field] **Relationship to You** [Optional field]

[optional field] **E-mail Address:**

Please Provide Your Medicare Insurance Information

<p>Please take out your red, white and blue Medicare card to complete this section.</p> <ul style="list-style-type: none"> • Fill out this information as it appears on your Medicare card. - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. 	<p>Name (as it appears on your Medicare card): _____</p> <p>Medicare Number: _____</p> <p>Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____</p> <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>
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Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, Electronic Funds Transfer (EFT) or credit card 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, 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 benefits check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Members Health Insurance Company.

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 your 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.

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.

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

Please select a premium payment option:

Receive a bill

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

Credit/ Debit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: _____

Expiration Date: __/__/____ (MM/YYYY)

Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.
I get monthly benefits from: Social Security RRB

(The Social Security/Railroad Retirement Board deduction 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 Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

If Social Security/Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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 Members Health Insurance Company?

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): _____

Please check one of the boxes below if you would prefer that we send you information in another language other than English or in another format:

_____ Spanish

_____ Braille or Large Print

Please contact Members Health Insurance Company at 1-855-540-4744 if you need information in another format or language. TTY users should call 711. Our office hours are Monday through Friday, 8 am to 8 pm.



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 Members Health Insurance Company 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 Members Health Insurance Company could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Members Health Insurance Company. 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:

Members Health Insurance Company 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 Members Health Insurance Company 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 Members Health Insurance Company 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.

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

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

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: _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Name of Plan Representative/agent/broker: _____

Members Health Insurance Company is a Part D plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal. You must continue to pay your Medicare Part B premium. Beneficiaries generally must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through 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 box if the statement applies to you. By checking any of the following boxes 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.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- I recently was released from incarceration. I was released on (insert date)_____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.
- I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date)_____.
- I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____.
- I recently left a PACE program on (insert date)_____.
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date)_____.
- I am leaving employer or union coverage on (insert date)_____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date)_____.

If none of these statements applies to you or you're not sure, please contact Members Health Insurance Company at (855) 540-4744 to see if you are eligible to enroll. We are open Monday through Friday 8 a.m. to 8 p.m. TTY users should call 711.

Applicant Signature _____ Date _____

Members Health Insurance Company is a Part D plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal. You must continue to pay your Medicare Part B premium. S2668_MHALFL18015 Accepted 07/17/2017