



AMERIHEALTH ADVANTAGE PDP MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

Please contact AmeriHealth Advantage PDP if you need information in another language or format (Braille).

A To Enroll in AmeriHealth Advantage PDP, Please Provide the Following Information:

Please check which plan you want to enroll in:

AmeriHealth Advantage PDP (001) Monthly Premium \$30.10

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: _____

Phone Number: □□□□-□□□□-□□□□ Relationship to You:

E-mail Address:

B 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.



SAMPLE ONLY

Name: _____

Medicare Claim Number Sex _____

□□□□□□□□□□ □□

Is Entitled To Effective Date
HOSPITAL (Part A) □□-□□-□□□□
MEDICAL (Part B) □□-□□-□□□□



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 coverage from your Medicare Advantage Plan that will meet your needs. By joining AmeriHealth Advantage 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 AmeriHealth Advantage PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AmeriHealth Advantage 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.

By completing this enrollment application, I agree to the following:

AmeriHealth Advantage PDP is a Medicare prescription 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 AmeriHealth Advantage 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 AmeriHealth Advantage 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 (November 15 – December 31), unless I qualify for certain special circumstances.

AmeriHealth Advantage PDP serves a specific service area. If I move out of the area that AmeriHealth Advantage 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 AmeriHealth Advantage PDP network pharmacies. Once I am a member of AmeriHealth Advantage 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 AmeriHealth Advantage PDP 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 AmeriHealth Advantage PDP, he/she may be paid based on my enrollment in AmeriHealth Advantage 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, 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 AmeriHealth Advantage PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AmeriHealth Advantage 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 AmeriHealth Advantage PDP or by Medicare.

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|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Signature: _____ | Today's Date: <div style="display: flex; justify-content: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</div> </div> |
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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:** _____

Medicare Prescription Drug Plan Use Only

Plan ID #: _____

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

Plan Representative/Agent/Broker Signature: _____