

Name of Plan you are enrolling in:			
Name:		Member No.:	
Home Phone Number:			
Permanent Street Address:			
Street Address:	City:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Street Address):			
Street Address:	City:	State:	ZIP Code:
Choose ONE of the two plans below by placing a check mark <input checked="" type="checkbox"/> in the box <input type="checkbox"/> . For more information on coinsurance, copayments, deductibles, and limitations for each plan, see your Summary of Benefits and/or Evidence of Coverage.			
<input type="checkbox"/> AmeriHealth Rx PDP Option 1		\$ 42.10	
<input type="checkbox"/> AmeriHealth Rx PDP Option 2		\$ 87.10	
<p>Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:</p> <p><input type="checkbox"/> Other language (please specify): _____ <input type="checkbox"/> Braille or audio tape</p> <p>Please contact AmeriHealth Rx PDP at 1-888-678-7007 if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY/TDD users should call 1-888-457-3002. However, please be aware that on weekends from February 15 through October 14, your call may be sent to an answering machine.</p>			
Your Plan Premium			
<p>You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or ZipCheck® (Electronic Funds Transfer) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefits check each month.</p> <p>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 benefit check or be billed directly by Medicare. DON'T pay AmeriHealth Rx PDP the Part D-IRMAA extra amount.</p> <p>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 qualify 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/TDD users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.</p> <p>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.</p> <p>If you don't select a payment option, you will get a bill each month.</p>			

Please select a premium payment option: Receive a bill Pay directly on ibxpress.com

ZipCheck from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number:

Account type:

Bank account number:

Checking

Saving

Automatic deduction from the monthly Social Security /Railroad Retirement Board benefit check. (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 the 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 Read and Sign Below:

AmeriHealth Rx PDP is a Medicare prescription drug plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with AmeriHealth Rx PDP, he/she may be compensated based on my enrollment in AmeriHealth Rx PDP.

Release of Information: By joining this Prescription Drug Plan, I acknowledge that the Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AmeriHealth Rx 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date AmeriHealth Rx PDP coverage begins, I must get all of my prescription drug services from AmeriHealth Rx PDP. Prescription drugs authorized by AmeriHealth Rx PDP and contained in my AmeriHealth Rx PDP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AmeriHealth Rx PDP WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf of the individual under the laws of the State where the individual resides) 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: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____