2025 Simply Prescriptions® Employer/Union Group Medicare Prescription Drug Plan Enrollment Form

simply Prescriptions®

Simply Prescriptions
Attn: Enrollment Operations
PO Box 31790
Rochester, NY 14603-1790

S3521_10310_C

B-3688Y25

Please contact Simply Prescriptions if you need information in another language or format (Braille).

For Internal Use

To Enroll in Simply Prescriptions, Please Provide the Following Information:

EMPLOYER OR UNION NAME:

GROUP #:

SUBGROUP/CLASS/ENROLLMENT CODE:

EFFECTIVE DATE (MM/DD/YYYY):

LAST NAME:

FIRST NAME:

MIDDLE INITIAL:

BIRTH DATE (MM/DD/YYYY):

SEX:
☐ MALE
☐ FEMALE

HOME PHONE NUMBER:
( )

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY:

COUNTY:

STATE:

ZIP CODE:

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

EMAIL ADDRESS:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- 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.

Simply Prescriptions is a PDP plan with a Medicare contract. Enrollment in Simply Prescriptions depends on contract renewal.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled to: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Paying Your Plan Premium

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.

Please read and answer these important questions:

1 Are you the retiree? ☐ YES ☐ NO

If yes, retirement date (month/date/year):

If no, name of retiree:

2 Do you or your spouse work and receive benefits through the employer? ☐ YES ☐ NO

If yes, please provide name of employer:

3 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 Simply Prescriptions? ☐ 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 coverage:

4 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: Phone Number of Institution:

Address of Institution (Number and Street):

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 Simply Prescriptions, 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 Simply Prescriptions could affect your employer or union health benefits.

You could lose your employer or union health coverage if you join Simply Prescriptions.
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 on the Next Page

Important: Read and Sign Below

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

Simply Prescriptions 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 Simply Prescriptions 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 Simply Prescriptions 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.

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

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 Simply Prescriptions will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Simply Prescriptions 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: RELATIONSHIP TO ENROLLEE:

ADDRESS: PHONE NUMBER:

Please send completed application to:
Simply Prescriptions, Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603-1790

Medicare Prescription Drug Plan Use Only: **Plan ID#:** _____

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

Name of plan representative/agent/broker (if assisted in enrollment): _____ Not Eligible: _____

Agent/Broker Signature: _____ **NPN: #**_____ **Date Received:** _____

All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term:_____
- ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer.**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP): _____

Email Address: _____