

# Medicare Part D Change Form



**National Rural Electric  
Cooperative Association**  
A Touchstone Energy® Cooperative

**Complete this form only if you are currently a participant in NRECA's Medicare Part D Prescription Drug Plans and you want to change to another NRECA Part D Plan.**



**Employer Information**

Subgroup Number	Employer Name
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**Type of Change**

**Open Enrollment** – change plans during annual open enrollment period

**Special Enrollment** (select reason below)

Eligible for low income subsidy (Extra Help)

Entering or leaving a health care institution (such as a nursing home)  
Date of move: \_\_\_\_\_

Other (please specify): \_\_\_\_\_

**Applicant Information**

First Name	Middle Initial	Last Name
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Member ID #	Preferred Language/Format: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
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**Plan Information**

I want to change from my current NRECA Part D Plan to the NRECA Part D Plan selected below. I understand that this Plan may have different prescription drug benefits and monthly premium. *See enrollment kit for plan benefits and monthly premiums.*

- Basic     Basic Plus     Copayment     Enhanced     Enhanced Plus

**Other Prescription Drug Coverage**

Insurer	ID Number	Group Number
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BIN	PCN	Effective Date	Termination Date
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**Authorization Signatures**

**By signing below, I acknowledge that I understand the Release of Information on the back of this form.**

Applicant Or Authorized Representative's Signature	Date
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If you are the authorized representative signing this form, please provide the following information:

First Name	Middle Initial	Last Name
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Address	City	State	ZIP
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Phone	Relationship To Applicant
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## Release of Information:

NRECA is a Medicare-approved Part D Plan sponsor and has a contract with the Federal government. By changing my enrollment in the NRECA Medicare Part D Prescription Drug Plan, an Employer PDP, I agree to continue to follow all rules for participation in the Plan, including 1) I can be in only one Medicare prescription drug plan at a time, 2) my coverage in another Medicare prescription drug plan, if any, will end with my enrollment in this Plan, 3) a premium must be paid for this coverage, 4) if I receive Extra Help from Medicare and Medicare pays only a portion of my Part D premium, then a premium must be paid for the amount that Medicare does not cover, 5) Part D coverage is in addition to my Medicare Part A or Part B coverage, which must also remain current, 6) I must use network pharmacies, except in an emergency, and 7) if Social Security notifies me that I must pay a Part D Income Related Monthly Adjustment Amount, I will pay this extra amount as directed or I may lose my Part D coverage. I will not pay this additional amount to the NRECA Medicare Part D Prescription Drug Plan.

I must tell the Plan of other drug coverage now or in the future. I may leave this Plan only during Open Enrollment, or under certain special circumstances, by contacting the Plan or 1-800-MEDICARE (TTY: 1-877-486-2048). If I leave this Plan and do not have or get other Medicare prescription drug coverage or other creditable prescription drug coverage (at least as good as Medicare's standard plan), I may have to pay a late enrollment penalty, imposed by Medicare, in addition to my Medicare Part D premium in the future, and I may lose my NRECA medical coverage, if any. I will read the Summary Plan Description and Evidence of Coverage and abide by the rules, such as the right to appeal plan decisions about payment or services. I acknowledge that my information may be released to Medicare and others as necessary for treatment, payment or health care operations, and Medicare may release it for research and other purposes as allowed by applicable Federal statutes and regulations.

The information on this enrollment form is correct to the best of my knowledge. I understand that 1) if I intentionally provide false information, I will be disenrolled from the Plan, 2) my signature (or the signature of my authorized representative) on this form means that I have read and understand the contents of this application. If signed by an authorized representative, this signature certifies that: 1) this person is authorized to act on my behalf under State law where I live to complete this enrollment and 2) documentation of this authority is available upon request by Medicare.

## Instructions for Medicare Part D Change Form

**For the applicant:** If you are concerned about a field, follow the instructions below. You do not need to complete the shaded areas of the enrollment form.

**For the administrator:** Complete all shaded areas as appropriate.

Employer Information	Provide information about the co-op or system.
Subgroup ID	Administrator completes.
Employer Name	Write the name of the co-op or system with which you are associated.
Type of enrollment	Provide information about the timing of your enrollment in Medicare Part D.
Election Type	<ul style="list-style-type: none"><li>• Check <b>Open Enrollment</b> if you are changing plans during an open enrollment period (October 15-December 7).</li><li>• Check <b>Special Enrollment</b> if you are changing plans and your circumstances match any of the reasons listed on the enrollment form. If you do not see your reason listed there, choose other and describe your reason. If you have questions, call the Member Contact Center at 1.866.673.2299.</li></ul>
Applicant Information	Provide information specific to the person applying for coverage.
Member ID Number	NRECA needs this number to verify that you are in their records.
First Name	Write your first name as it appears on your Medicare ID card.
Last Name	Write your last name as it appears on your Medicare ID card.
Preferred Language	Check the language in which you prefer to receive written communication.
Plan information	Check the NRECA Part D Plan in which you want to enroll. See brochure for descriptions of the plans.
Other Prescription Drug Coverage	If you are covered under more than one prescription drug plan (such as spouse's coverage, VA benefit, Tricare, or State Pharmaceutical Assistance Program), fill in the information from your insurance card for that plan, including the insurer's name, your ID number, the effective date, the term date, the Group, BIN and PCN numbers for that coverage. (NRECA is not considered other coverage.)
Authorization Signatures	You or your authorized representative must sign this form.