

# Medicare Part D Enrollment Form



National Rural Electric  
Cooperative Association  
A Touchstone Energy® Cooperative

**NRECA**  
**Medicare**  
**Part D**  
PRESCRIPTION DRUG PLANS  
*an Employer PDP*

**MedicareRx**  
Prescription Drug Coverage

Employer Information				
Subgroup Number	Employer Name			
Type of Enrollment				
<b>Election Type:</b> <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment				
If you choose Special Enrollment, which best describes you?				
<input type="checkbox"/> <b>Retiring</b> over age 65. <b>Retirement date:</b> _____				
<input type="checkbox"/> <b>Eligible</b> for low-income subsidy (Extra Help)				
<input type="checkbox"/> <b>Losing</b> creditable coverage. <b>Date of loss</b> of creditable coverage: _____				
<input type="checkbox"/> <b>Entering or leaving</b> a health care institution (such as a nursing home) <b>Date of move:</b> _____				
<input type="checkbox"/> <b>Other (please specify):</b> _____				
Applicant Information				
Member ID #	First Name	Middle Initial	Last Name	
Date Of Birth	Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Medicare Claim Number (Check your Medicare Card):				
<b>Which one of these best describes you?</b>			<b>For disabled applicants only:</b>	
<input type="checkbox"/> Retired Employee			Date of eligibility for Medicare	
<input type="checkbox"/> Retired Director			<input type="checkbox"/> Disabled Director	
<input type="checkbox"/> Medicare Eligible Spouse			<input type="checkbox"/> Disabled Medicare Eligible Spouse	
<input type="checkbox"/> Disabled Employee			<input type="checkbox"/> Disabled Medicare Eligible Child	
<input type="checkbox"/> Disabled Retiree			Preferred Language/Format: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
<b>Administrator:</b> If the applicant was an employee, please complete the following fields: Hire date: _____ Separation date: _____				
<b>If Medicare Eligible Spouse, Disabled Medicare Eligible Spouse or Disabled Medicare Eligible Child is chosen above, please complete the following fields:</b>				
Employee Member ID #	Employee First Name	Middle Initial	Employee Last Name	
Employee Date Of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Administrator:</b> Complete the following fields: Hire date: _____ Separation date: _____ Disability date: _____				
Permanent Address (No P.O. Boxes)	City	State	ZIP	Phone
Mailing Address (if different)	City	State	ZIP	

Are you a resident of a long-term facility such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the following information:			
Facility Name			
Facility Address	City	State	ZIP
<b>Plan Information</b>			
<b>CHOOSE A PLAN:</b> (See your enrollment kit for monthly premiums.)			
<input type="checkbox"/> Basic <input type="checkbox"/> Basic Plus <input type="checkbox"/> Copayment <input type="checkbox"/> Enhanced <input type="checkbox"/> Enhanced Plus			
<b>Other Prescription Drug Coverage</b>			
Insurer	ID Number	Group Number	
BIN	PCN	Effective Date	Termination Date
<b>Authorization Signatures</b>			
<b>By signing below, I acknowledge that I understand the Release of Information below.</b>			
Applicant Or Authorized Representative's Signature			Date
If you are the authorized representative signing this form, please provide the following information:			
First Name	Middle Initial	Last Name	
Address	City	State	ZIP
Phone	Relationship To Applicant		

**Release of Information:**

NRECA is a Medicare-approved Part D Plan sponsor and has a contract with the Federal government. By joining the NRECA Medicare Part D Prescription Drug Plan, an Employer PDP, I agree that 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.

# Medicare Part D Enrollment Form Instructions



**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>Initial Enrollment</b> if you are applying in the 7-month period when you first become eligible for Medicare.</li> <li>• Check <b>Open Enrollment</b> if you are enrolling in or changing plans during an open enrollment period (October 15-December 7).</li> <li>• Check <b>Special Enrollment</b> if you are enrolling in or 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.
Medicare Claim Number	This number appears on your Medicare card. Fill it in exactly as it appears on your card. <div style="text-align: right; border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> </div>
Date of Eligibility for Medicare	If you are disabled and applying for Medicare Part D, fill in the date you became eligible for Medicare. This date usually differs from your date of disability.
Preferred Language	Check the language in which you prefer to receive written communication.
Permanent Residence Address	Write the address that you consider your permanent residence, not a second home or vacation home. Do not use a P.O. Box.
Mailing Address	If you receive the majority of your mail at an address other than your permanent residence, write the address here. You may use a P.O. Box.
Are you a resident of a long-term care facility such as a nursing home?	Check yes or no. If yes, fill in the long-term care facility information. If no, go to Plan Information.
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.