Horizon

Please return application to Group, Union, and/or Broker when completed.

MEDICARE PRESCRIPTION DRUG PLAN GROUP ENROLLMENT FORM

To enroll in Horizon Medicare Blue Group Rx (PDP), please provide the following information:

Employer or Union Name: _____

Medicare Advantage Group # (if known): _____

Please Provide Information About You *(Please print clearly)*

Requested effective date of coverage:

☐☐ / ☐☐ / ☐☐☐☐

Birth Date: ☐☐ / ☐☐ / ☐☐☐☐

Sex: ☐ M ☐ F

Home Phone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

☐ Mr. ☐ Mrs. ☐ Ms.

LAST Name: ☐☐☐☐☐☐☐☐☐☐ FIRST Name: ☐☐☐☐☐☐ Middle Initial: ☐

Permanent Residence Street Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(PO Boxes are not allowed. Applications submitted with a PO Box will not be processed.)

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ ZIP Code: ☐☐☐☐☐

Mailing Address (only if different from your Permanent Residence Address):

Street Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ ZIP Code: ☐☐☐☐☐

Email Address*:(optional) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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.

Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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.

*By providing your email address, you agree to receive communications from Horizon BCBSNJ via email.

Please Answer the Following Questions

1. 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 Horizon Medicare Blue Group Rx (PDP)?

☐ 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 this coverage: _____

2. 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: _____

Address and phone number of institution
(number and street): _____

_____

Please contact Horizon Blue Cross Blue Shield of New Jersey at **1-888-425-9435** (TTY users should call **711**) if you need information in an accessible format or additional language. Our office hours are Monday through Sunday, 8 a.m. to 8 p.m., Eastern Time (ET), October 1 to March 31 and Monday through Friday, 8 a.m. to 8 p.m., ET, April 1 to September 30.

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 Horizon Medicare Blue Group Rx (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 Horizon Medicare Blue Group Rx (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Horizon Medicare Blue Group Rx (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.

Please Read and Sign Below

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

Horizon Medicare Blue Group Rx (PDP) 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 Horizon Blue Cross Blue Shield of New Jersey 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 Horizon Medicare Blue Group Rx (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, unless I qualify for certain special circumstances.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Horizon Medicare Blue Group Rx (PDP) network pharmacies. Once I am a member of Horizon Medicare Blue Group Rx (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 Horizon Blue Cross Blue Shield of New Jersey 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 Horizon Blue Cross Blue Shield of New Jersey, he/she may be paid based on my enrollment in Horizon Medicare Blue Group Rx (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.

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 benefit check or be billed directly by Medicare or the RRB. DO NOT pay Horizon Blue Cross Blue Shield of New Jersey the Part D-IRMAA.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Horizon Blue Cross Blue Shield of New Jersey will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Horizon Blue Cross Blue Shield of New Jersey 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 Horizon Blue Cross Blue Shield of New Jersey or by Medicare.

Your Signature: _____ Today's Date: _____

If you want to identify a personal representative, you must complete a "Request for Personal Representative" form which will allow you to identify another person who can speak on your behalf.

Medicare Prescription Drug Plan Use Only

Plan ID #: _____

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

Name of Plan Representative/Agent/Broker: _____

Horizon Insurance Company ("HIC") contracts with CMS to offer group-Medicare Advantage plans and group Part D Prescription Drug plans. Enrollment in HIC Medicare products depends on contract renewal. Products are provided by HIC and Horizon Blue Cross Blue Shield of New Jersey, both of which are independent licensees of the Blue Cross and Blue Shield Association. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies.