Thank you for choosing...

First Health® Part D
from Coventry Health Care

Enrolling is Simple.
Just Follow These 4 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Choose your plan and premium:

1. First Health Part D Premier - $43.90/month

OR

2. First Health Part D Premier Plus - $99.70/month

Step 2

SELECT THE TYPE OF BILLING YOU WANT – by checking
account deduction, receive a coupon book, or automatic deduction from your Social Security benefit check. Make sure you sign and date the application

Step 3

SIGN AND DATE THE APPLICATION

If you have any questions, or you are not sure how to answer a question, simply contact your agent at: (630) 930-9364

Step 4

FAX THE COMPLETED APPLICATION TO:
Fax: (847) 220-9280

We will be in contact with you upon receipt of your completed application. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from Coventry First Health.

First Health® Part D
from Coventry Health Care

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

FAX#: (847) 220-9280

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

- ❑ Please contact me at this phone number after you have reviewed my application for completeness and accuracy _____.
- ❑ Please contact me at this email after you have reviewed my application for completeness and accuracy _____.

First Health® Part D (PDP) Medicare Prescription Drug Plan Individual Enrollment Form

Please contact First Health Part D if you need information in another language or format (Braille).

To Enroll in First Health Part D Prescription Drug Plan (PDP), Please Provide the Following Information: (Please print in capital letters.)

Please check which plan you want to enroll in - CHOOSE ONLY ONE BOX (your enrollment will be processed based on the box you check, not the premium amount you indicate)

☐ First Health Part D Premier (PDP) $_____ per month

☐ First Health Part D Premier Plus (PDP) $____ per month

Refer to your Summary of Benefits to look up the premium amount for your benefit plan.

What effective date of coverage are you applying for? ____ / ____ / ____
MM / DD / YYYY

Please choose the enrollment period that you are applying for:

☐ Initial Enrollment Period (IEP) ☐ Annual Enrollment Period (AEP) ☐ Special Enrollment Period (SEP)

NOTE: *Please refer to the Enrollment Checklist on page 2. Effective dates are based on the enrollment period you are using to enroll and the Centers for Medicare & Medicaid Services' regulations. Coventry cannot guarantee that the effective date you have requested will be honored.*

Is this a plan change within Coventry? ☐ **Yes** ☐ **No**

LAST Name:	**FIRST Name:**	**Middle Initial:**	☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**

Birth Date: ____ / ___ / ____ MM / DD / YYYY	**Sex:** ☐ Male ☐ Female	**Home Phone Number:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Permanent Residence: (P.O. Box is not allowed):

Street Address:

City: County: State: ZIP Code:

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

Street Address:

City: County: State: ZIP Code:

Email Address: (optional)_____

☐ By checking this box, I give Coventry permission to contact me electronically regarding member information.

Please Provide Your Medicare Insurance Information

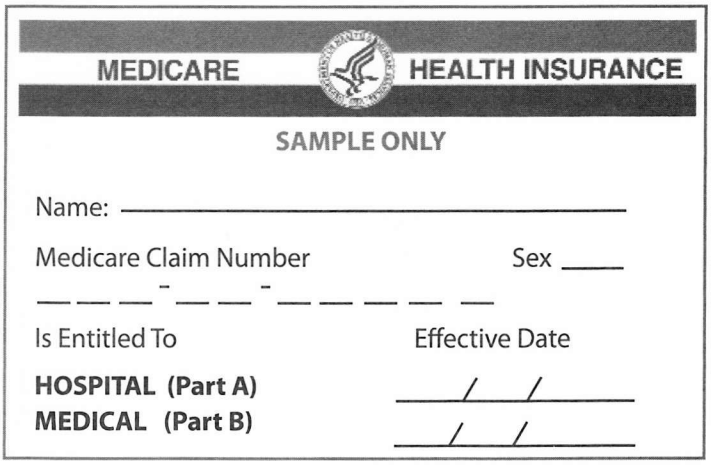
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card. Make sure you include all letters and numbers.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.



Release of Information: By joining this Medicare prescription drug plan, I acknowledge that First Health Part D will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that First Health Part D 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.

Your Signature or Authorized Representative as described above ▶ Today's Date ____/____/_____

Signature of person who assisted you in completing this Enrollment Form. ▶ Today's Date ____/____/_____

If you are the Authorized Representative and/or Power of Attorney, you must also sign above and provide the following information:

☐ Authorized Representative ☐ Power of Attorney

Name: _____ Phone Number: (__ __ __)__ __ __-__ __ __ __

Street Address/City/State/ZIP: _____

Relationship to Enrollee: _____

As an Authorized Representative, please select where all mailings should be sent:

☐ Send to enrollee mailing address

☐ Send to Authorized Representative mailing address

☐ Send to both addresses

If you are the Agent/Producer/Broker, you must provide the following information and submit with the completed application:

Was the Scope of Appointment (SoA) required? (SoA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.) ☐ Yes ☐ No

If "no", why not? _____

Was the SoA captured electronically or telephonically? ☐ Yes ☐ No

If "yes", please provide confirmation number (electronic SoA): _____

Is the SoA (if not electronic) attached? ☐ Yes ☐ No

Agent/Producer/Broker Information:

Print Agent/Producer/Broker name: Ryan Kennelly

Agent Writing Number (AWN) 1__ 7__ 7 4 4 7__ ___

Agent #1 (if applicable) _____

Agent #2 (if applicable) _____

NOTE: If Agent/Producer/Broker takes receipt of this application, signature and date are required below:

Signature of Agent/Producer/Broker _____

Date Individual Enrollment Request Form received By Agent ____/____/_____

Agent/Producer/Broker: Please be sure to copy and maintain this and all pages of the completed application for your records.

First Health Part D Internal Use Only

Plan ID #: _____ IEP: _____ AEP: _____ SEP: (type) _____

Plan Representative/Agent/Broker: _____

Paying Your Plan Premium

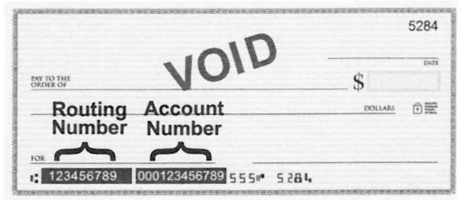
You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), 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 RRB benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to First Health Part D.

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 coinsurance. 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.

<u>If you don't select a payment option, you will receive a coupon book.</u>
<u>Please select a premium payment option:</u>

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please complete the information below and **attach a personal VOIDED check** (not a business check) **or savings withdrawal slip** (not a deposit slip) to the Enrollment Form and provide the following:



Account Holder Name: ______________________________
(Please enter the name as it appears on the account to be debited.)

Bank Name: ______________________________

Bank Address: ______________________________

ROUTING NUMBER: |: ☐☐☐☐☐☐☐☐☐ |:

ACCOUNT NUMBER: ☐☐☐☐☐☐☐☐☐☐ ||■

CHECK NUMBER: 9 9 9 9 ||■

Account Type: ☐ Checking ☐ Savings

Signature of Account Holder: (if different than enrollee) ______________________________

○ I agree that this authorization will remain in effect until I provide written notification terminating this service. Request must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due for the current month.

☐ Receive a coupon book (which will be mailed to you) to pay for your monthly premium.

☐ Automatic deduction from your monthly Social Security/RRB benefit check. ***(The Social Security/RRB deduction may take two or more months to begin.*** *In most cases, if Social Security/RRB accepts your request for automatic deduction, the first deduction from your Social Security/RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums. If you receive a coupon book it is important that you submit your monthly plan premium payment to Coventry Health Care, Inc. until your deductions begin.)*

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 <u>prescription</u> drug coverage in addition to First Health Part D? ☐ 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: ______________

Please note that having other coverage may not exclude you from joining First Health Part D.

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 (number & street, city, state, ZIP) & Phone Number of Institution: _____

3. 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: ☐ Spanish ☐ Large Print
Please contact First Health Part D at 1-877-815-8163 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 – February 14 and 8 a.m. to 8 p.m., Monday – Friday, from February 15 – September 30. TTY users should call 711.

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 First Health Part D, 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 First Health Part D could affect your employer or union health benefits. You could lose your employer or union health coverage if you join First Health Part D. 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 Form, I agree to the following:
First Health Part D 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 First Health Part D 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 First Health Part D 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.

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

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.