Office of Management and Enterprise Services
Employees Group Insurance Division
APPLICATION FOR MEDICARE SUPPLEMENT WITH PART D

Member ID #_____ Phone (_____) _____

E-mail Address _____ Alternate Phone # (_____) _____

Member's Name _____
First M.I. Last

Dependent's Name _____
(if enrolling in Medicare) First M.I. Last

Permanent Residence _____
(P.O. Box is not allowed) Street City State Zip Code

Mailing Address _____
(if different than above) Street City State Zip Code

If your dependent is the person enrolling in Medicare, all the information and questions relate to them.

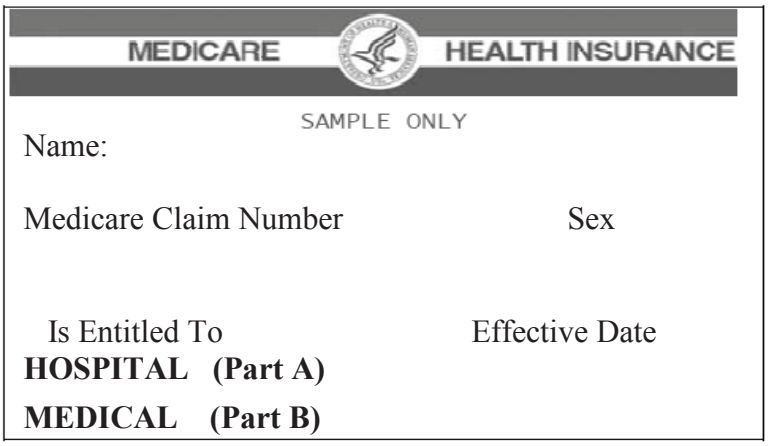
Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in the blanks to the right so they match your red, white, and blue Medicare card.

-OR-

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


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medicare Claim Number Sex

Is Entitled To Effective Date

HOSPITAL (Part A)

MEDICAL (Part B)

HealthChoice Medicare Supplement Plan coverage becomes effective as of the date you become eligible for Medicare, or the 1st of the month following the Plan's notification of your Medicare eligibility, whichever is later. All medical benefits under this Plan are paid as if you are enrolled in both Medicare Parts A and B. If you are not enrolled in Medicare Part B, the Plan will estimate Medicare's benefits and provide supplemental coverage as if Medicare is the primary carrier. This means that HealthChoice pays secondary, and you are responsible for the primary share of the claim.

Please Answer the Following Questions

1. In which Medicare Supplement With Part D plan do you want to enroll?

HealthChoice Employer PDP Medicare Supplement with Part D ☐ High ☐ Low

2. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Do you have other **prescription** drug coverage in addition to HealthChoice? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for your coverage:
Name of other coverage: _____ ID #: _____ Group #: _____

Revised 09/12/2013