Release of Information:

By joining this Medicare supplement prescription drug plan, I acknowledge that the Medicare Supplement With Part D plans offered by EGID will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that they 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 EGID or Medicare.

Member Signature: _____ Date: _____

(You must return the first four pages of this form to EGID at the address listed below.)

Dependent Signature: _____ Date: _____

(Required only if dependent is enrolling in Medicare.)

For information about the Medicare Supplement With Part D plans offered by EGID, contact:

Office of Management and Enterprise Services
Employees Group Insurance Division
3545 NW 58th Street, Suite 110 Oklahoma City, OK 73112
1-405-717-8780 or toll free 1-800-752-9475 or TDD 1-405-949-2281 or toll free 1-866-447-0436