Office of Management and Enterprise Services
Employees Group Insurance Division
APPLICATION FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLAN
A separate application must be submitted for each Medicare beneficiary enrolling.

Member ID #_____ Phone # (_____) _____

Email Address_____ Alternate Phone # (_____) _____

Member Name _____
First M.I. Last

Member SSN _____ Member Date of Birth _____ Sex ☐ M ☐ F

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

Dependent SSN _____ Dependent Date of Birth _____ Sex ☐ M ☐ F

Permanent Residence_____
(P.O. Box is not allowed) Street City State ZIP Code County

Mailing Address_____
(if different than above) Street City State ZIP Code County

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

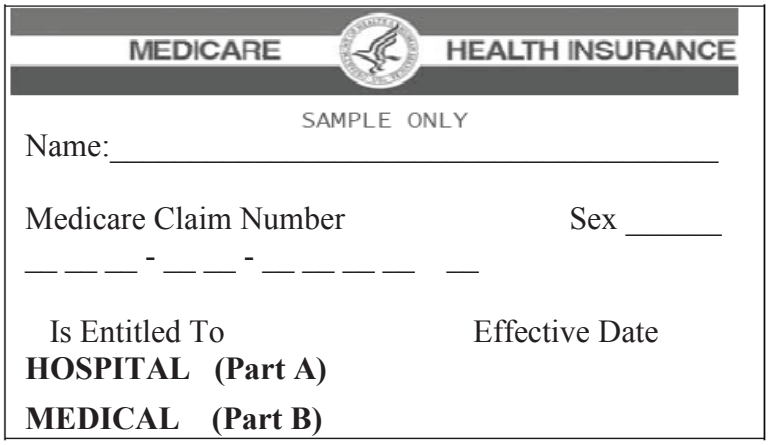
Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- 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)

You must have Medicare Part A and Part B to join an MA-PD plan.

Please Answer the Following Questions

1. In which MA-PD plan do you want to enroll?

CommunityCare Senior MA-PD ☐

Generations Healthcare MA-PD ☐