2. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, ***please attach a note or records*** *from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise, the MA-PD plan may need to contact you to obtain additional information.*

3. Some individuals may have other prescription drug coverage through private insurance, TRICARE, federal employee health benefits coverage, VA benefits, worker's compensation, or state pharmaceutical assistance programs. Do you have other **prescription** drug coverage? ☐ Yes ☐ No

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

Typically, you can enroll in an MA-PD plan *only* during the Annual Enrollment Period *from* October 15 *through* December 7 of each year. Please check the box below if you are enrolling during an Annual Enrollment Period.

☐ I am enrolling during an Annual Enrollment Period (Option Period).

There are exceptions that may allow you to enroll in an MA-PD plan outside of this period.

4. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside of the service area of my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.

☐ I get Extra Help paying for Medicare prescription drug coverage.

☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on (insert date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.