



**ODS ADVANTAGE PRESCRIPTION DRUG PLAN
INDIVIDUAL ENROLLMENT FORM**

For individuals enrolling in Medicare Part D

ODS Health Plan, Inc.

601 S.W. Second Avenue • Portland, OR • 97204

503-265-4762 • 1-877-299-9062 • TTY: 1-800-433-6313

MEDICARE PRESCRIPTION DRUG PLAN USE

ONLY:

Plan ID #: _____

Effective Date of Coverage: _____

IEP: _____ AEP: _____

SEP (type): _____

Plan Representative Signature: _____

MEDICARE NUMBER			SOCIAL SECURITY NUMBER (optional)		
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F		TELEPHONE NUMBER (AREA CODE + NUMBER)		
<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS.	LAST NAME		FIRST NAME		MIDDLE INITIAL
PERMANENT RESIDENCE ADDRESS			MAILING ADDRESS (IF DIFFERENT)		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

PRESCRIPTION DRUG PLAN CHOICE	PREMIUM
ODS ADVANTAGE Rx Extra Enhanced Prescription Drug Plan	<input type="checkbox"/> \$55.40
ODS ADVANTAGE Rx Prescription Drug Plan	<input type="checkbox"/> \$36.80

YOUR PLAN PREMIUM PAYMENT

OPTION: You can pay your Medicare drug plan directly for your monthly premium, or have the monthly premium automatically deducted from your Social Security check. If you choose to pay directly, you can pay by mail or by electronic funds transfer (EFT). Generally, you must stay with the option you choose for the rest of the year. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want to pay your remaining premium, if there is any, directly to your plan. **Do you want to pay your premium directly to your plan (this can include an automatic monthly deduction from your bank account)?** YES NO

If you check "no," we will contact you about having your premiums automatically deducted from your Social Security check.

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS:

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 prescription drug coverage in addition to ODS Advantage Rx? 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: _____

2. Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs? YES NO

If you answer "no," your premium may be increased because of a late enrollment penalty. If you answer "yes," we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standards prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.Medicare.gov or call 1-800-MEDICARE.

3. 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 and street) and phone number of institution: _____



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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 **OR** attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug plan.

MEDICARE HEALTH INSURANCE	
Medicare Claim Number: _____	
Name: _____	
Sex: _____	Is Entitled To: _____
Part A: _____ Effective date (mo/day/yr)	Part B: _____ Effective date (mo/day/yr)

PLEASE READ AND SIGN BELOW: By completing this enrollment application, I agree to the following: ODS Advantage Rx is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform ODS Advantage Rx 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. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to ODS Advantage Rx or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

ODS Advantage Rx serves a specific service area. If I move out of the area that ODS Advantage Rx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of ODS Advantage Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from ODS Advantage Rx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

RELEASE OF INFORMATION: By joining this Medicare prescription drug plan, I acknowledge that ODS Advantage Rx will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. 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 behalf of the individual under the laws of the state where the individual resides) 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 ODS Advantage Rx or by Medicare.

Your Signature: _____ Today's Date: _____

If you are the authorized representative, you must provide the following:

Name: _____ Relationship to enrollee: _____

Address: _____ Phone number: _____

As an an agent contracted with ODS Health Plan, Inc., I, _____ (name and agency), am authorized to discuss plan options with you. I may be compensated based on your enrollment in a plan.