OMB No. 0938-1378
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INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Members Health Insurance Company
P. O. Box 240
Columbia, TN 38402

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Members Health Insurance Company at 1-844-368-8739. TTY users can call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Members Health Insurance Company al 1-844-368-8739/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

☐ Farm Bureau **Select Rx**: - **$76.70** per month ☐ Farm Bureau **Essential Rx**: - **$37.10** per month

FIRST name: LAST name: (Optional: Middle Initial)

Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	(Required) County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Your Medicare information:

Medicare number: __ __ __ __ - __ __ __ - __ __ __ __

Hospital (Part A) Effective Date: _____

Medical (Part B) Effective Date: _____

Information is located on your red, white and blue Medicare card.

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Farm Bureau Select Rx/Essential Rx? ☐ Yes ☐No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group/Policy number for this coverage: _____

Effective date for this coverage: _____

Do you work? ☐ Yes ☐ No

If yes, do you have other health care coverage from your employer? ☐ Yes ☐ No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group/Policy number for this coverage: _____

Effective date for this coverage: _____

Does your spouse work? ☐ Yes ☐ No

If yes, do you have other health care coverage from your employer? ☐ Yes ☐ No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group/Policy number for this coverage: _____

Effective date for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) or Medical (Part B) to stay in Members Health Insurance Company.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Members Health Insurance Company will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- I understand that when my Members Health Insurance Company coverage begins, I must get all of my prescription drug benefits from Members Health Insurance Company. Benefits and services provided by Members Health Insurance Company and contained in my Members Health Insurance Company "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Members Health Insurance Company will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:
Broker Information	
Broker/Agent name:	Broker/Agent ID number:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin

☐ Yes, Mexican, Mexican American, Chicano/a

☐ Yes, Puerto Rican

☐ Yes, Cuban

☐ Yes, another Hispanic, Latino/a, or Spanish origin

☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ White

☐ **I choose not to answer.**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Members Health Insurance Company at 1-844-368-8739 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week October 1 - March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 - September 30 our hours are 8 a.m. to 8 p.m. Monday - Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY users can call 711.

Additional Contact Information

Email Address: _____

Alternate Phone Number: _____

Paying your plan premiums

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail, Electronic Funds Transfer (EFT), credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

☐ Direct Bill ☐ Bank Withdrawal (EFT) ☐ Social Security or RRB

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Members Health Insurance Company the Part D-IRMAA.

Office Use Only:

SEP Type: _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of Eligibility for an Enrollment Period

PO Box 240
Columbia, TN 38402

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- ☐ I recently was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). 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 (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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____.

☐ 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)_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Members Health Insurance Company at 1-844-368-8739 (TTY users should call 711) to see if you are eligible to enroll. Our hours of operation are 8 a.m. to 8 p.m. local time, 7 days a week October 1 – March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 – September 30 our hours are 8 a.m. to 8 p.m., Monday – Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY user should call 711.