

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

- AmeriHealth Advantage is a Medicare prescription drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage.
- It is my responsibility to inform AmeriHealth Advantage 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 – if I am currently in a Medicare prescription drug plan, my enrollment in AmeriHealth Advantage will end that enrollment.
- Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for certain special circumstances, by sending a request to AmeriHealth Advantage or by calling 1-800-MEDICARE, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.
- AmeriHealth Advantage serves a specific service area. If I move out of the area that AmeriHealth Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
- I understand that I must use network pharmacies to access AmeriHealth Advantage benefits, except under limited, non-routine circumstances when I cannot reasonably use AmeriHealth Advantage network pharmacies. Once I am a member of AmeriHealth Advantage, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the Evidence of Coverage document from AmeriHealth Advantage when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
- I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with AmeriHealth Advantage, he/she may be compensated based on my enrollment in AmeriHealth Advantage. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information:

- By joining this Medicare prescription drug plan, I acknowledge that AmeriHealth Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AmeriHealth Advantage 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 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 AmeriHealth Advantage or by Medicare.

Your Signature: _____**Today's Date:**

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If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: - - **Relationship to Enrollee:** _____

Medicare Prescription Drug Plan Use Only

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative/Agent/Broker Signature: _____