OMB No. 0938-1378 Expires:6/30/2026

BlueRx℠
A Medicare Approved Part D Plan

BlueRx (PDP) Medicare Prescription Drug Plan Individual Enrollment Request Form

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:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing
P.O. Box 2768
Birmingham, Alabama 35202-2768
Fax Number: 1-888-246-0230

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

How do I get help with this form?

Call BlueRx (PDP) **at 1-877-233-3555 (AL) / 1-855-617-6760 (TN). 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 BlueRx (PDP) al **1-877-233-3555 (AL) / 1-855-617-6760 (TN) (TTY 711)** o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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SECTION 1: All fields in this section are required (unless marked optional).

Select the plan you want to join:	
☐ **BlueRx Essential (PDP)**	**$63.20** Per Month
☐ **BlueRx Enhanced Plus (PDP)**	**$129.30** Per Month

FIRST Name	LAST Name	MIDDLE Initial

Birth Date MM-DD-YYYY	Sex	Phone Number
☐☐ – ☐☐ – ☐☐☐☐	☐ Male ☐ Female	(☐☐☐) – ☐☐☐ – ☐☐☐☐

Email Address (Optional)

Permanent Residence Street Address *(Don't enter a P.O. Box here)*
Note: *For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.*

Street Address			
City	County	State	Zip

Mailing Address, if different from street address *(P.O. Box allowed)*

Street Address			
City	State	Zip	

Enter your Medicare number here: ☐☐☐☐ – ☐☐☐ – ☐☐☐☐

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueRx (PDP)? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

SECTION 1: All fields in this section are required. (continued)

IMPORTANT: Read and sign below.

- I must keep Hospital (Part A) or Medical (Part B) to stay in BlueRx (PDP).
- By joining this Medicare Prescription Drug Plan, I acknowledge that BlueRx (PDP) 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 BlueRx (PDP) coverage begins, I must get all of my prescription drug benefits from BlueRx (PDP). Benefits and services provided by BlueRx (PDP) and contained in my BlueRx (PDP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueRx (PDP) 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 MM-DD-YYYY
	– –

If you're the authorized representative, sign above and fill out the fields below.

Name	Phone Number
	( ) – –
Address	Relationship to enrollee

Agent Use

Representative Code #1:	Representative Signature:	Date Received:
		– –
Representative Code #2:	**Representative Signature:**	**Date Received:**
		– –

SECTION 2:
All fields on this page 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 of Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or of 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 Indian ☐ Black or African American ☐ Chinese
☐ Filipino ☐ Japanese ☐ Guamanian or Chamorro ☐ Korean
☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan
☐ Vietnamese ☐ White ☐ **I choose not to answer.**

What is your gender? Select one. ☐ Woman ☐ Man ☐ Non-Binary
☐ I use a different term: _____ ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual
☐ I use a different term: _____ ☐ I don't know ☐ **I choose not to answer.**

Select one if you want us to send you information in an accessible format or language other than English.

☐ Audio CD ☐ Braille ☐ Data CD ☐ Large Print ☐ For language other than English: _____

Please contact BlueRx (PDP) **at 1-877-233-3555 (AL), 1-855-617-6760 (TN)** if you need information in an accessible format or language other than what is listed above. **Our office hours are Monday – Friday, 8 a.m. – 8 p.m. CST.** From October 1 to March 31, the hours of operation are **Monday – Sunday, 8 a.m. – 8 p.m. CST.** You may be required to leave a message for calls made after hours, weekends and holidays. Calls will be returned the next business day. **TTY users can call 711.**

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center: _____

Paying your plan premiums - Please select a payment option below.

☐ You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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.**

I get monthly benefits from: ☐ **Social Security** ☐ **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 BlueRx (PDP) the Part D-IRMAA.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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.

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BlueRx is a PDP with a Medicare contract. Enrollment in BlueRx (PDP) depends on contract renewal.

BlueRx (PDP) is provided by Blue Cross and Blue Shield of Alabama and UTIC Insurance Company, independent licensees of the Blue Cross and Blue Shield Association.