



Mail applications to:
Riverview Membership Accounting - MS21103R
PO BOX 9463
Minneapolis, MN 55440

HealthPartners® Freedom Medicare Prescription Drug Program - for Minnesota residents only

Each individual must complete a separate enrollment form.

You are eligible to join a HealthPartners® Freedom Medicare Prescription Drug program if:

- **You are enrolled in or are enrolling in HealthPartners® Freedom Medical plans II or III. HealthPartners® Freedom Medical Plan I is not eligible for drug coverage.**
- You are enrolled in the Federal Medicare Program for Part A (hospital coverage) AND Part B (medical coverage) or you are enrolled in Part B only; and
- You live in the plan's service area. This eligibility condition does not apply if you are already a commercial member of HealthPartners. However, if you move to a different out-of-area address after the initial enrollment, Medicare requires HealthPartners to disenroll you from the plan; and
- Are enrolling during an approved enrollment period. (See Section Four for additional information.)

Important information:

- HealthPartners must receive your **completed, signed and dated** enrollment form by the last working day of the month before you want coverage to begin. Coverage always begins on the first day of a future month.
- You cannot enroll in the HealthPartners® Freedom Enhanced Prescription Drug plan if your current or former employer helps pay for your drugs.

Medicare_{Rx}
Prescription Drug Coverage

- **Your billing option will be the same as you selected on your HealthPartners® Freedom Medical plan enrollment form.**
- After we receive your enrollment form, we will send you a member identification card and letter stating when your coverage begins.
- Beneficiaries interested in assistance for Medicare Prescription Drug costs subsidies may contact HealthPartners Medicare Sales at the numbers listed on the back of this application. You may also contact Medicare at 1-800-MEDICARE (TTY users call 1-877-486-2048) 24 hours a day/7 days a week. Or you may contact your State Medicaid Office, or local Social Security Administration Office.

To enroll, please follow these steps:

- 1) Fill out the entire enrollment form except shaded areas. Incomplete or incorrect enrollment forms may delay the effective date of your coverage. Use a ballpoint pen and press firmly to ensure clear carbon copies.
- 2) Provide a **PHOTOCOPY** of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form. **Or you may fill out the information in Section Three exactly as it appears on your Medicare card.**
- 3) Select one prescription drug option:
 - Standard prescription plan
 - Standard Plus prescription plan
 - Enhanced prescription plan
- 4) **Carefully read, sign and date the enrollment form.**
- 5) **Retain the yellow copy for your records.** Mail the white copy to HealthPartners in the enclosed postage-paid envelope. Please put all completed forms from this enrollment packet in the same envelope.

HealthPartners is a health plan with a Medicare contract.

HealthPartners® Freedom Medicare Prescription Drug Program Enrollment Form

SECTION ONE: Personal information

Last Name	First Name	M. I.	Social Security Number
Date of Birth (MM/DD/YY)	Home Phone (area code)	Work Phone (area code)	
Permanent Home Address Apt. No.			

Broker Name JAY PETERSON
Agency No. 3818
HEALTHPARTNERS USE ONLY
Eff. Date _____
MR# _____
Ctct # _____

City	State	ZIP Code	County
Mailing Address (if different from permanent home address)			Apt. No.
City	State	ZIP Code	County

Male Female

SECTION TWO: Prescription drug plan selection

Your billing option will be the same as you selected on the HealthPartners® Freedom medical plan enrollment form. Generally you must stay with the billing option you choose for the rest of the calendar year.

Choose **ONE** prescription drug option:

- Standard - \$5.60 with Medical Plan II; \$8.20 with Medical Plan III
- Standard Plus - \$52.90 with Medical Plan II or III
- Enhanced - \$125.20 with Medical Plan II or III

Please note: HealthPartners® Freedom Medicare Prescription Drug plans are only available if you are enrolled or enrolling in HealthPartners® Freedom Medical Plan II or III. You cannot choose Enhanced if your current or former employer helps pay for your drugs.

If you have qualified for additional assistance for your Medicare Prescription Drug Program costs, the amount of your premium and cost at the pharmacy will be less. Once you have enrolled in HealthPartners® Freedom Medicare Prescription Drug program, Medicare will tell us how much assistance you are receiving and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact 1-800-MEDICARE (TTY users call 877-486-2048), your State Medicaid Office, or local Social Security Administration Office to see if you might qualify. The Medicare offices are open 24 hours a day, 7 days a week.

SECTION THREE: Medicare information

Please take out your Medicare Card to complete this section.

Please fill in the blank card to the right so it matches 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.

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY _____	
CLAIM NUMBER _____	SEX _____
IS ENTITLED TO _____	EFFECTIVE DATE _____
HOSPITAL INSURANCE (PART A) _____	
MEDICAL INSURANCE (PART B) _____	
SIGN HERE ↴	

SECTION FOUR: Please answer the following questions

Typically you may enroll in a Medicare Prescription Drug plan during the annual enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug plan outside of these periods. Some of the questions below will help us determine which enrollment period you are enrolling under.

Many people can join in this plan and keep the current prescription coverage that they already have. This includes other private insurance, Worker's Compensation, VA benefits, State assistance programs, and any other coverage you may have for your prescriptions. In order for Medicare to coordinate these benefits, please list any current coverage you have for prescription drugs that you plan to keep.

I plan to keep additional prescription coverage. YES NO
If YES, what is the name of the company providing your other coverage? _____
What is your identification number (ID number) for this coverage? _____

1. Are you a resident of an long term care facility (for example, a nursing home)? YES NO
If YES, Name of Institution: _____
Address of Institution (number and street): _____
Phone Number of Institution: _____ Your Date of Admission: _____

2. Do you live in a long term care facility (for example, a nursing home)? YES NO

3. Did you recently move "out" of a long term care facility (for example, a nursing home)? YES NO

4. Do you have both Medicare and Medicaid or does the state help pay for your Medicare premiums? YES NO

5. Are you either losing coverage you had from an employer or leaving employer coverage? YES NO
If YES, when does this coverage end ? _____ (MM/DD/YYYY)

Please check with your benefits administrator about any decision to join another health plan. Joining one could affect your employer or union health benefits.

6. Did you recently move outside the service area of your current plan? YES NO
If YES, what was your move date? _____
(MM/YYYY)

7. Do you receive extra help paying for Medicare prescription drug coverage? YES NO

Please read this important information

If you are in a Medicare Advantage Plan (like an HMO or PPO), joining the HealthPartners® Freedom Medicare Prescription Drug Program means that you will no longer be in your Medicare Advantage plan. You don't have to do anything to cancel your membership in your Medicare Advantage plan. By joining the HealthPartners® Freedom Medicare Prescription Drug Program, you will now get your health care from the HealthPartners® Freedom plan. You should call your health plan if you are unsure if you have a Medicare Advantage plan.

SECTION FIVE: Authorization and acknowledgement

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

HealthPartners® Freedom Medicare Prescription Drug plan is a Medicare drug plan and is in addition to my coverage under Medicare Parts A and/or B; therefore, I will need to keep my Parts A and/or B. I must continue to pay the premiums for my Medicare Part A and/or B. I can only be in one Medicare prescription drug plan at a time. If I enroll in this plan, I will be automatically disenrolled from all other Medicare Part D plans. If I enroll in two Part D plans with the same effective date, both transactions will be cancelled. 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 HealthPartners or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048. Medicare is open 24 hours a day, 7 days a week. HealthPartners® Freedom Medicare Prescription Drug plan serves a specific geographic service area. If I move out of the service area that HealthPartners® Freedom Medicare Prescription Drug plan 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 HealthPartners® Freedom Medicare Prescription Drug plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthPartners® Freedom Medicare Prescription Drug plan 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 plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program. I understand that, beginning on the date my HealthPartners® Freedom plan coverage begins, I must get all of my health care from HealthPartners, with the exception of emergency or urgently needed services to receive plan coverage. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by HealthPartners and other services contained in my HealthPartners® Freedom plan Evidence of Coverage will be covered.

I also acknowledge that HealthPartners 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 guidelines. 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 my signature on this application means that I have read and understand the contents of this application. Note: To find out more about the rules and procedures you must follow in order to receive coverage, please read the HealthPartners® Freedom plan Evidence of Coverage. (This will be sent to you automatically once you are enrolled or upon request.)

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.

Generally enrollment begins the first day of the month after HealthPartners receives your completed form and verifies your eligibility.

STOP Do you currently have health coverage from an employer or union group? If so, talk with your benefits administrator about your decision to join a Medicare Prescription Drug Program. Joining a Medicare Prescription Drug Program could affect your employer or union health benefits.

To enroll in a HealthPartners® Freedom Medicare Prescription Drug plan, you MUST be enrolled or enrolling in HealthPartners® Freedom Medical Plan II or III.

Your Signature* _____ Date _____

* If the individual cannot sign, a court-appointed legal guardian or person with Power of Attorney, if authorized by state law; or another person who is authorized by state law, must sign the following line. Attach a copy of proof of Legal Guardian, Power of Attorney, or proof of authorization by state law.

Signature _____ Date _____

If anyone helped the applicant fill out this form, she or he must sign below:

Please sign here: _____ Relationship: _____ Date: _____

Medicare Prescription Drug Plan use only: Plan ID #: _____ Effective Date of Coverage: _____

IEP: _____ AEP: _____ SEP (type): _____ Plan Representative Signature: _____

For questions regarding medical and dental plans, call 952-883-5601 or 1-800-247-7015, Monday - Friday, 8 a.m. to 6 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.

For questions about Medicare Part D prescription drug benefits, including copayments, deductibles and network pharmacies, call 952-883-5601 or 1-800-247-7015, seven days a week, 8 a.m. to 8 p.m. TTY users should call 952-883-6060 or 1-800-443-0156.



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