

Navitus (PDP) for PRISM Medicare Prescription Plan Benefit Election Form

Group Name: _____

Effective Date: _____

MEMBER ENROLLMENT OR CHANGE – COMPLETE IN FULL			
Name (Last, First, MI):		Social Security #:	Birth Date (mm/dd/yy): ☐ Male ☐ Female
Home Street Address: (No P.O. Box) City, State, Zip		Home Phone:	Work Phone:
Mailing Address: (P.O. Box may be used) City, State, Zip ☐ Same as Home Address		E-mail Address:	
Occupation/Title:	Date of Hire: (mm/dd/yy):	Employee Status: ☐ Medicare Retiree	
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced			

MEDICARE SECTION		
Are you retired?	☐ Yes ☐ No	If yes for Medicare for you and/or your dependent(s), please provide your and/or their HICN/MBI number and indicate the entitlement reason and Medicare eligibility date for yourself and your dependents. HICN/MBI Number: _____ Entitlement Reason ☐ Over 65 ☐ Disabled ☐ ESRD Effective Date of Medicare: _____
If yes, what Medicare are YOU enrolled in?	☐ Part A ☐ Part B	
Is your dependent (s) enrolled in Medicare?	☐ Yes ☐ No	Name: _____

If Yes for dependent, what Medicare are they enrolled in?	☐ Part A ☐ Part B	HICN Number: _____
		Date of Birth: _____
		Gender: _____
		Relationship: _____
		Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
		Effective Date of Medicare: _____

Enroll In Employer Group Waiver Program (Navitus Medicare PDP)

☐ Retiree ☐ Spouse

PLEASE READ THE FOLLOWING- AUTHORIZATION REQUIRED

I declare that the information given on this form is true and complete to the best of my knowledge and belief. I understand that the information I have provided is the basis on which coverage may be issued under these plans. Any misstatements or omissions may result in future claims being denied and/or my coverage(s) being rescinded. I know that if I do not enroll within 30 days of becoming first eligible (or within 31 days of an IRS-qualified change in status) I will have to wait until the next annual enrollment and may be required to submit evidence of insurability for certain coverage.

Signature: _____	Date: _____
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DECLINATION OF COVERAGE – SIGNATURE REQUIRED- Complete only if declining EGWP Rx coverage

I understand that I am eligible for medical and Rx coverage through my employer. I waive the right to enroll in the medical plan and Rx plan as offered to me by my employer for the following reason (please check one):

☐ I am covered under another Medicare Advantage/Supplement Plan I
☐ am covered through my spouse's employer
☐ I have no other coverage but choose not to enroll

I understand that by declining coverage, I will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child, or involuntarily losing my other coverage). Please contact the Benefits Office at the organization from which you retired for retiree plan provisions.

Signature: _____	Date: _____
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