OBM No. 0938-1378
Expires: 06/30/2026

Individual Enrollment Request Form to Enroll in a Medicare Prescription Drug Plan (Part D)

BlueCross BlueShield Kansas

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 Kansas
PO Box 517
Topeka, Kansas 66601-9872

Or fax to: 1-866-445-0417

You can also enroll online at:
https://www.bcbsks.com/partd

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

How do I get help with this form?
Call Blue Cross and Blue Shield of Kansas at **1-877-471-4121**. 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 Blue Cross and Blue Shield of Kansas al 1-877-471-4121/711 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.

Medicare Prescription Drug Plan Individual Enrollment Form – 2025

BlueCross BlueShield Kansas

Section 1 – Applicant Information (All fields in this section are required unless noted otherwise.)

Please select the plan you want to enroll in.

☐ 013 Blue MedicareRx Value (PDP) – $39.60 per month

☐ 014 Blue MedicareRx Plus (PDP) – $61.60 per month

☐ 020 Blue MedicareRx Essentials (PDP) – $0.00 per month

First Name _____ MI (Optional) _____

Last Name _____

Permanent Residence Street Address (Do not enter a P.O. Box)* _____

City _____

State _____ ZIP Code _____ +4 _____ County (Optional) _____

Mailing Address (if different from residential address; P.O. Box allowed) _____

City _____

State _____ ZIP Code _____ +4 _____

Sex ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

(_____) _____-_____
Phone Number

(_____) _____-_____
Alternate Phone Number

* For individuals experiencing homelessness, a P.O. Box may be considered your permanent resident address.

E-mail Address (Optional) _____

Thank you for providing your email address. Your email is used to send plan information and member communications. Please select which materials you would like to have emailed (you may select more than one):

☐ Plan documents

☐ Member communications

You will receive hard copies of specific plan documents on an annual basis and by request.

You can change your communications preferences at any time by visiting **www.myprime.com** or by contacting customer service.

Section 1A – Your Medicare Information

Enter the **11-digit alpha-numeric number** located on your Medicare card (for example: 1EG4-TE5-MK72).

Medicare Number _____

_____ /_____ /_____
Part A Effective Date

_____ /_____ /_____
Part B Effective Date

Section 1B – Other Prescription Drug Coverage

Will you have other prescription drug coverage (i.e., VA, TRICARE) in addition to Blue Cross and Blue Shield of Kansas? ☐ Yes ☐ No

Name of Other Coverage _____

Group Number of Other Coverage _____

Member Number of Other Coverage _____

_____ /_____ /_____
Start Date of Coverage

_____ /_____ /_____
End Date of Coverage

Please continue on the next page.

Section 2 – Demographic Information

All fields in this section are optional. Answering these questions is your choice. **You cannot be denied coverage because you don't fill them out.**

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

- ☐ No, not of Hispanic, Latino/a or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, other Hispanic, Latino/a or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ I choose not to answer

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- • Native Hawaiian or Pacific Islander
  - ☐ Guamanian or Chamorro
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ I choose not to answer
- • Asian
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian

What is your gender? Select one.

- ☐ Woman
- ☐ Non-binary
- ☐ I choose not to answer
- ☐ Man
- ☐ I use a different term: _____

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

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

Would you like us to provide information in an accessible format? If yes, please check one of the boxes below:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Blue Cross and Blue Shield of Kansas at **1-877-471-4121** if you need information in an accessible format or language other than those listed above. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31; and Monday through Friday (except holidays) from April 1 through September 30. 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: _____

Applicant complete: _____ (Name) _____ (Medicare Number)

Please continue on the next page.

Section 3 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or by electronic funds transfer (EFT) 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.**

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. Do not pay Blue Cross and Blue Shield of Kansas the Part D-IRMAA.

Please select a premium payment option. If you don't select a payment option, you will get a bill each month.

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your first payment.

Select the account type to deduct from:

☐ Checking (you may enclose a **voided** check or provide the account information at right)

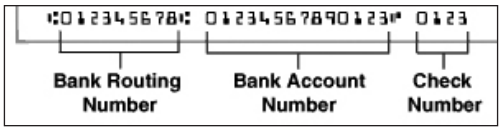
☐ Savings (you **must** enclose a letter from your financial institution with the account and routing information)

Account Holder Name

Bank Name

Bank Routing Number

Bank Account Number



I authorize the bank noted above to deduct my monthly premiums.

☐ **Automatic deduction from your my monthly** ☐ **Social Security or** ☐ **Railroad Retirement Board (RRB) benefit check.**

The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 4 – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan (PDP) only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year. Additionally, there are exceptions – i.e., Initial Enrollment Period (IEP) and Special Enrollment Periods (SEPs) – 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 all of the boxes where there is a statement that 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.

NOTE: At least one option below needs to be selected to enroll.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 through December 7. (AEP)
- ☐ I am new to Medicare. (IEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ I recently moved outside 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) _____ /_____ /_____. (SEP)
- ☐ 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. (SEP)
- ☐ 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) _____ /_____ /_____. (SEP)
- ☐ 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 governmental entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (SEP)
- ☐ I recently had a change in my Medicaid/Extra Help paying for my Medicare prescription drug coverage (newly got Medicaid/Extra Help, had a change in the level of Medicaid/Extra Help, or lost Medicaid/Extra Help) on (insert date) _____ /_____ /_____. (SEP)
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____ /_____ /_____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____ /_____ /_____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ /_____ /_____. (SEP)
- ☐ I am leaving employer or union coverage. Employer/union coverage started on (insert date) _____ /_____ /_____ and coverage ends on (insert date) _____ /_____ /_____. (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ /_____ /_____. (SEP)

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 4 – Attestation of Eligibility for an Enrollment Period (continued)

☐ My plan is ending its contract with Medicare or Medicare is ending its contact with my plan. (SEP)

☐ I was recently released from incarceration. I was released on (insert date) _____ /_____ /_____. (SEP)

☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____ /_____ /_____. (SEP)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)

☐ Other* _____

*If none of these statements apply to you or you're not sure, please contact Blue Cross and Blue Shield of Kansas at **1-877-471-4121** (TTY users should call 711) to see if you are eligible to enroll. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31; and Monday through Friday (except holidays) from April 1 through September 30.

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 5 – Authorization

Please read the following and sign below.

- I acknowledge I must keep Hospital (Part A) or Medical (Part B) to stay in Blue MedicareRx Value (PDP), Blue MedicareRx Plus (PDP) or Blue MedicareRx Essentials (PDP).
- By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross and Blue Shield of Kansas 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.
- 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.

Your signature required

_____ _____ / _____ / _____
Applicant Date Signed

_____ _____ / _____ / _____
Print Name Desired Plan Effective Date*

*Subject to Medicare electon period guidelines.

Section 6 – Authorized Representative Information

All fields in this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.

_____ _____ _____
First Name MI Address

_____ _____
Last Name City

(_____) _____-_____ _____ _____ _____ _____
Phone Number Relationship to Enrollee State ZIP Code +4

☐ I have submitted Authorized Representative documentation with this application.

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 7 – Agent/Broker

Applicant: Please do **not** complete the following sections.

Agent/Broker: Please fill in **all** fields including "Writing Agent" and "Agency" with your assigned Encrypted ID, Code or Tax ID based on your appointed brand, state and product.

☐ IEP ☐ AEP ☐ OEP ☐ SEP _____
Type

☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Scope of Appointment (SOA)

Appointment type:

☐ Face-to-face

☐ Telephone

How was the SOA collected?

☐ Paper

☐ Electronic

☐ Recorded call _____
Voice Recording ID

_____
NPN Number

_____
First Name

_____
Last Name

_____
Writing Agent Encrypted TIN (10 digits)

_____
Agency Encrypted TIN (10 digits)

_____
Agency Name

(_____) _____-_____
Phone Number

_____
E-mail Address

_____
Representative Relationship to Applicant

1 – Agent
2 – Broker
3 – SHIP Counselors
4 – Authorized Rep
5 – Other third parties
6 – Self

Your signature required

_____
Signature of Agent/Broker

_____ / _____ / _____
Date Signed

Blue Cross and Blue Shield of Kansas (BCBSKS) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Part D plans noted. BCBSKS is an independent licensee of the Blue Cross Blue Shield Association.

Translation services are available; please contact the plan or your agent.

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. Section 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.

Applicant complete: _____ _____
Name Medicare Number