



How to submit a completed Medicare Part D Paper Application to CIGNATURE Rx.

As you know, it is critical that applications are complete prior to submission to CIGNATURE Rx and that they are submitted to CIGNATURE Rx in a timely manner. This ensures that the member is quickly established in CIGNATURE Rx systems so that members may access the benefit and that producers are paid commissions in a timely manner. Those fields highlighted below **must be completed**—if not, the application will be considered incomplete and be delayed.

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CIGNATURESM Medicare Prescription Drug Plan X

CIGNATURE Rx MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

To Enroll in CIGNATURE Rx, Please Provide The Following Information:

Please check which plan you want to enroll in:

- CIGNATURE Rx Value Plan
- CIGNATURE Rx Plus Plan
- CIGNATURE Rx Complete Plan

Ensure one (1) of the plans is checked

First Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: _____ Sex: _____ Social Security Number: _____ Home Phone Number: _____

Permanent Address:

City: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

City: _____ State: _____ ZIP Code: _____

Emergency Contact: Optional field Phone Number: Optional field Relationship to You: Optional field

E-Mail Address: Optional field

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your Medicare Card.
- A
- B

This section must be completed

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

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Your Plan Premium Payment Option:

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by check or credit card. **Ensure selections are made here**

If you qualify for Medicare, you may cover all or some portion of your plan premium. Please choose if you want the remaining premium if this is not deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? Yes No

Please Answer the Following Questions:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other prescription drug coverage in addition to CIGNATURE Rx? Yes No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

2. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage (creditable coverage) since you became eligible to join a Medicare drug plan? Yes No

If no, you may have to pay a penalty. CIGNATURE Rx may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have any questions about the late enrollment penalty, call CIGNATURE Rx at 1-800-8235-1459.

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If "yes" please provide the following information:

Name of Institution: _____
Address & Phone Number of Institution (number and street): _____

STOP Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining CIGNATURE Rx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining CIGNATURE Rx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining CIGNATURE Rx may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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Please Read and Sign Below:

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

CIGNATURE Rx is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform CIGNATURE Rx 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. 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 CIGNATURE Rx or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048.

CIGNATURE Rx serves a specific service area. If I move out of the area that CIGNATURE Rx 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 CIGNATURE Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CIGNATURE Rx 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 Medicare prescription drug plan, I acknowledge that CIGNATURE Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 on this application means that I, the individual, or 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 CIGNATURE Rx or by Medicare.

Client must sign and date

Your Signature: _____ Today's Date: _____

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

Name: _____
Address: _____
Phone Number: (____) _____
Relationship to Enrollee: _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____
Effective Date of Coverage: _____ (type): _____
Plan Representative: _____

Producer Use Only:

Producer Last Name: _____ Producer First Name: _____
National Producer Number (NPN): _____ Producer License Number #: _____
Producer General Agency: _____
Location Signed: City: _____ State: _____
Producer Signature: _____ Date: _____
Producer Phone: (____) _____ Producer E-mail: _____
* License Number in State where policy was sold.

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Enter CIGNATURE Rx Agent ID Here
Enter General Agency Here

Mail Completed Apps to:
CIGNATURE Rx
P.O. Box 269005
Weston, FL 33326

Fax Completed Apps to:
1-800-735-1469

OR

Your Agent ID: _____
Your General Agency: Senior Market Sales - 1024