



Mutual of Omaha Rx Medicare Prescription Drug Plan Individual Enrollment Form 2019
 Please contact Mutual of Omaha RxSM (PDP) if you need information in another language or format (braille).

To enroll in Mutual of Omaha Rx, please provide the following information:

Please check which plan you want to enroll in: (For monthly premiums, please see the back of this form.)
 Plus Value

LAST Name:

FIRST Name: Middle Initial: Mr. Mrs. Ms.

Birth Date: -- Sex: M F Home Phone: --
 M M D D Y Y Y Y Cell Phone: --

Permanent Residence Street Address (P.O. Box is not allowed):

City: State: ZIP Code:

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

City: State: ZIP Code:

Email Address:

Emergency Contact:

Relationship to You: Phone Number: --

Please provide your Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section.

> Fill out this information as it appears on your Medicare card.

OR

> Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: **HOSPITAL (Part A)** Effective Date:

M M D D Y Y Y Y

MEDICAL (Part B)

M M D D Y Y Y Y

Please select a premium payment option:

- Receive a bill: If you would like to pay by credit card, please contact us at 1.877.770.9808 when you receive your confirmation of enrollment letter. TTY users should call 1.866.544.2982. Our office hours are 8 a.m. to 9:30 p.m. Eastern, Monday through Friday.
- Automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check.

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



Please read this important information:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Mutual of Omaha 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 coverage. 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 Mutual of Omaha Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Mutual of Omaha Rx. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign on the following page:

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

Mutual of Omaha Rx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Mutual of Omaha 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 – if I am currently in a Medicare prescription drug plan, my enrollment in Mutual of Omaha Rx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Mutual of Omaha Rx serves a specific service area. If I move out of the area that Mutual of Omaha Rx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Mutual of Omaha Rx network pharmacies. Once I am a member of Mutual of Omaha 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 Mutual of Omaha Rx to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Mutual of Omaha Rx, he/she may be paid based on my enrollment in Mutual of Omaha Rx. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of information:

By joining this Medicare prescription drug plan, I acknowledge that Mutual of Omaha Rx will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Mutual of Omaha Rx 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 regulations. 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 authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by 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 Medicare.

Your Signature: Today's Date: --
M M D D Y Y Y Y

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

FIRST Name: Middle Initial:

LAST Name:

Address of Representative (number and street):

City: State: ZIP Code:

Phone Number: --

Relationship to Enrollee:

For applicants receiving assistance from a broker or agent:

The person who is discussing plans with you is either employed by or contracted with Mutual of Omaha Rx. The person may be compensated based on your enrollment in a plan.

Broker/Agent Name:

National Producer Number:

Agency:

Carrier #: Broker/Agent/Representative Signature:

Information to determine enrollment periods:

Typically, you may enroll in a Medicare prescription drug plan only during the Annual Enrollment Period from October 15 through December 7 of each year. Additionally, there are exceptions 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 the box if the statement 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.

I am new to Medicare.

I recently moved outside of 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):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I recently was released from incarceration. I was released on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I recently obtained lawful presence status in the United States. I got this status on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

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.

I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I recently left a PACE program on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I am leaving employer or union coverage on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I belong to a pharmacy assistance program provided by my state.

My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

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

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):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

I recently had a change in my Medicaid (newly got Medicaid, had a change in the level of Medicaid assistance, or lost Medicaid) on (insert date):

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

If none of these statements applies to you or you're not sure, please contact Mutual of Omaha Rx at 1.800.961.9006 to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m., 7 days a week (except Thanksgiving and Christmas). TTY users should call 1.800.584.6939.

Mutual of Omaha Rx 2019 premiums:

Region	Service Area	Plus	Value
01	ME/NH	\$48.10	\$27.10
02	CT/MA/RI/VT	\$41.20	\$26.40
03	NY	NA	NA
04	NJ	\$41.40	\$26.40
05	DC/DE/MD	\$41.90	\$28.40
06	PA/WV	\$42.30	\$26.40
07	VA	\$41.50	\$27.00
08	NC	\$45.60	\$28.00
09	SC	\$41.70	\$26.70
10	GA	\$46.70	\$29.00
11	FL	\$44.40	\$29.30
12	AL/TN	\$45.40	\$28.80
13	MI	\$49.00	\$31.00
14	OH	\$39.10	\$24.70
15	IN/KY	\$41.90	\$27.00
16	WI	\$46.70	\$31.40
17	IL	\$45.80	\$28.10
18	MO	\$47.10	\$28.70
19	AR	\$51.60	\$33.60
20	MS	\$51.80	\$30.90
21	LA	\$52.30	\$32.10
22	TX	\$44.80	\$29.20
23	OK	\$46.10	\$29.50
24	KS	\$44.20	\$29.40
25	IA/MN/MT/ND/NE/SD/WY	\$47.00	\$30.20
26	NM	\$48.20	\$30.80
27	CO	\$37.00	\$24.80
28	AZ	\$38.10	\$25.20
29	NV	\$39.70	\$26.00
30	OR/WA	\$45.00	\$29.40
31	ID/UT	\$45.50	\$27.40
32	CA	\$43.30	\$27.60
33	HI	\$41.30	\$26.60
34	AK	\$49.00	\$28.00
38	PR	NA	NA

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.961.9006 (TTY: 1.800.584.6939).

Mutual of Omaha Rx (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in the Mutual of Omaha Rx plan depends on contract renewal.

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