OMB No. 0938-1378
Expires: 7/31/2024

Medicare Prescription Drug Plan Individual Enrollment Form for 2024

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 and 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 listed under REQUIRED INFORMATION. Completing items marked as optional or listed under OPTIONAL INFORMATION is your choice. 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.
- If you are a member of a Medicare Advantage Plan (like an HMO or PPO) with prescription drug coverage, or if you currently have health coverage from an employer or union, your coverage could be affected by joining Mutual of Omaha Rx. Read the communications that your Medicare Advantage Plan, employer or union sends you. If you still have questions, please contact your Medicare Advantage Plan or benefits administrator.

Individuals experiencing homelessness
If you want to join a plan but have no permanent residence, you may use a Post Office Box (P.O. Box), an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) as your permanent residence address.

What happens next?
Send your completed and signed form to:
Mutual of Omaha Rx
P.O. Box 3625
Scranton, PA 18505

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

How do I get help with this form?
Call Mutual of Omaha Rx at **1.800.961.9006** (TTY users, call **711**). Or, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users, call 1.877.486.2048.

En español: Llame a Mutual of Omaha Rx al **1.800.961.9006** (los usuarios de TTY deben llamar al **711**), o a Medicare gratis al 1.800.633.4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Mutual of Omaha Rx Medicare Prescription Drug Plan Individual Enrollment Form 2024

Please contact Mutual of Omaha Rx℠ (PDP) if you need information in another language or format.

REQUIRED INFORMATION to enroll in Mutual of Omaha Rx (PDP):

Please check which plan you want to join: (For monthly premiums, please see the back page of this form.)

☐ **Plus** ☐ **Essential** ☐ **Premier**

LAST Name:

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

Birth Date: M M - D D - Y Y Y Y

Sex: ☐ M ☐ F

Home Phone: - -

Cell Phone: - -

Permanent Address (P.O. Box not allowed except for homeless individuals):

City: **State:** **ZIP Code:**

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

City: **State:** **ZIP Code:**

Email Address (optional):

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 Mutual of Omaha 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:

Medicare insurance information:

Please take out your red, white and blue Medicare card to complete this section. In addition, you may also attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Medicare Number (Medicare Beneficiary Identifier):

				-				-				
				-				-				

Name (as it appears on your Medicare card)*:

*This information is optional

Entitled To:

HOSPITAL (Part A) Coverage Starts*: M M - D D - Y Y Y Y

MEDICAL (Part B) Coverage Starts*: M M - D D - Y Y Y Y

IMPORTANT – Please read and sign:

Release of information:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Mutual of Omaha Rx.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Mutual of Omaha Rx 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 on the back page of this form).
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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.
- 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:

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

Proposed Effective Date of Coverage (optional): M M - D D - Y Y Y Y

Effective dates are based on the enrollment period you are using and the Centers for Medicare & Medicaid Services regulations. Unless you are new to Medicare or are eligible for a Special Enrollment Period (SEP), your effective date will be January 1. Mutual of Omaha Rx cannot guarantee that the effective date you have requested will be honored. Ultimately, CMS provides the Part D enrollment effective date.

FOR AUTHORIZED REPRESENTATIVE ONLY: Completion of this section is required ONLY if you are a person acting on behalf of the applicant under State law.

FIRST Name:

Middle Initial:

LAST Name:

Address of Representative (number and street):

City:

State:

ZIP Code:

Phone Number:

– –

Relationship to Enrollee:

OPTIONAL INFORMATION

FOR BROKER/AGENT ONLY: Complete this section ONLY if you are a broker/agent providing assistance to the applicant. You must be affiliated with a brokerage agency that is contracted with and authorized by Mutual of Omaha Rx to sell our plans.

Broker/Agent Name:

National Producer Number: (Numeric Characters Only)

Broker/Agent/Representative Signature:

Today's Date:

M M - D D - Y Y Y Y

OPTIONAL INFORMATION

Answering these questions is your choice.
You can't be denied coverage because you don't fill them out.

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

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

What is your race? Select all that apply.

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ **I choose not to answer**

Select if you want us to send you information in a language other than English.

- ☐ Spanish

Select one if you want us to send you information in an accessible format.

- ☐ Braille
- ☐ Large print

Please contact Mutual of Omaha Rx at **1.800.961.9006** if you need information in an accessible format other than what's listed above. TTY users, call **711.** Our office hours between October 1 and March 31 are 8 a.m. to 8 p.m., 7 days a week (except Thanksgiving and Christmas). Between April 1 and September 30, our office hours are 8 a.m. to 8 p.m., Monday through Friday (except federal holidays).

Go paperless! Reduce your clutter and help the environment.

- ☐ I prefer that you send materials to me via email, if available. I understand that I can switch my preference back to mail at any time.

E-mail address: _____

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 want to enroll during the Annual Enrollment Period.
- ☐ I am new to Medicare and want to enroll during my Initial Enrollment Period.
- ☐ 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): M M - D D - Y Y Y Y
- ☐ I recently was released from incarceration. I was released on (insert date): 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): 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): 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): 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): M M - D D - Y Y Y Y
- ☐ I recently left a PACE program on (insert date): 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): M M - D D - Y Y Y Y
- ☐ I am leaving employer or union coverage on (insert date): 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): 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): M M - D D - Y Y Y Y
- ☐ Other (explain) _____(insert date): M M - D D - Y Y Y Y

If 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 between October 1 and March 31 from 8 a.m. to 8 p.m., 7 days a week (except Thanksgiving and Christmas). Between April 1 and September 30, our office hours are 8 a.m. to 8 p.m., Monday through Friday (except federal holidays). TTY users, call **711.**

Long-term care facility information:

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 Facility:

Address of Facility (number and street):

City: **State:** **ZIP Code:**

Phone Number:
– –

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or electronic funds transfer 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 Mutual of Omaha Rx the Part D-IRMAA.

Please select a premium payment option:

☐ Receive a bill.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check and provide the following information:

By selecting EFT, I authorize Omaha Health Insurance Company to withdraw the necessary amounts from the account provided to pay the plan premium owed by me under my Mutual of Omaha Rx contract. Automatic withdrawal will occur on the first day of each month.

Bank Routing Number: **Bank Account Number:**

Account Type:

☐ **Checking** ☐ **Savings**

Name on Account (if different from name of enrollee):

☐ 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.

Mutual of Omaha Rx (PDP) 2024 premiums for each plan:

Region	Service Area	Plus	Essential	Premier
01	NH, ME	$96.30	$26.80	$90.10
02	CT, MA, RI, VT	$110.80	$27.90	$102.40
03	NY	NA	NA	NA
04	NJ	$98.00	$24.40	$89.50
05	DE, DC, MD	$89.10	$26.30	$84.60
06	PA, WV	$41.20	$24.90	$88.20
07	VA	$96.50	$25.00	$84.40
08	NC	$81.20	$24.90	$65.40
09	SC	$42.60	$25.10	$78.60
10	GA	$94.90	$23.60	$86.80
11	FL	$103.80	$24.20	$118.60
12	AL, TN	$116.90	$23.60	$73.00
13	MI	$35.40	$23.20	$75.00
14	OH	$85.00	$24.10	$86.50
15	IN, KY	$97.10	$24.10	$69.50
16	WI	$46.30	$22.10	$77.80
17	IL	$93.10	$24.00	$66.90
18	MO	$104.60	$23.40	$70.90
19	AR	$37.70	$22.80	$74.80
20	MS	$99.00	$23.20	$95.10
21	LA	$43.10	$24.60	$77.10
22	TX	$99.90	$23.70	$77.10
23	OK	$93.20	$22.90	$79.30
24	KS	$92.20	$22.00	$67.20
25	IA, MN, MT, ND, NE, SD, WY	$40.90	$22.90	$70.30
26	NM	$94.70	$22.40	$53.30
27	CO	$104.30	$22.80	$100.70
28	AZ	$103.20	$22.90	$67.50
29	NV	$97.20	$23.30	$81.80
30	OR, WA	$105.50	$23.00	$83.00
31	ID, UT	$41.90	$20.30	$71.60
32	CA	$112.30	$25.70	$100.30
33	HI	$94.90	$23.10	$79.20
34	AK	$97.70	$24.20	$81.30

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.961.9006** (TTY: **711**).

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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.