

HEALTH NET ORANGE (PDP) MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM



Please contact Health Net Orange if you need information in another language or format (Braille).

To Enroll in Health Net Orange, Please Provide the Following Information:

Please check which plan you want to enroll in:

Alabama/Tennessee

- Option 1 – \$33.50 per month
- Option 2 – \$69.40 per month

Alaska

- Option 1 – \$63.70 per month
- Option 2 – \$78.40 per month

Arizona

- Option 1 – \$25.00 per month
- Option 2 – \$82.70 per month

Arkansas

- Option 1 – \$25.30 per month
- Option 2 – \$60.80 per month

California

- Option 1 – \$31.90 per month
- Option 2 – \$87.60 per month

Central New England:

(Connecticut/Massachusetts/
 Rhode Island/Vermont)

- Option 1 – \$33.60 per month
- Option 2 – \$87.30 per month

Colorado

- Option 1 – \$41.60 per month
- Option 2 – \$70.60 per month

Florida

- Option 1 – \$27.90 per month
- Option 2 – \$75.10 per month

Georgia

- Option 1 – \$34.50 per month
- Option 2 – \$71.60 per month

Hawaii

- Option 1 – \$30.00 per month
- Option 2 – \$47.60 per month

Idaho/Utah

- Option 1 – \$40.30 per month
- Option 2 – \$75.50 per month

Illinois

- Option 1 – \$40.80 per month
- Option 2 – \$77.30 per month

Indiana/Kentucky

- Option 1 – \$37.40 per month
- Option 2 – \$80.30 per month

Kansas

- Option 1 – \$39.40 per month
- Option 2 – \$73.10 per month

Louisiana

- Option 1 – \$34.60 per month
- Option 2 – \$64.90 per month

Michigan

- Option 1 – \$36.60 per month
- Option 2 – \$61.90 per month

Mid-Atlantic: (Delaware/District of Columbia/
 Maryland)

- Option 1 – \$34.80 per month
- Option 2 – \$63.30 per month

Mississippi

- Option 1 – \$29.40 per month
- Option 2 – \$64.90 per month

Missouri

- Option 1 – \$38.50 per month
- Option 2 – \$73.20 per month

Nevada

- Option 1 – \$26.60 per month
- Option 2 – \$75.30 per month

New Jersey

- Option 1 – \$56.10 per month
- Option 2 – \$96.50 per month

New Mexico

- Option 1 – \$24.00 per month
- Option 2 – \$66.20 per month

North Carolina

- Option 1 – \$36.00 per month
- Option 2 – \$76.00 per month

Northern New England:
 (Maine/New Hampshire)

- Option 1 – \$39.10 per month
- Option 2 – \$67.10 per month

Please check which plan you want to enroll in:

Ohio

- Option 1 – \$39.10 per month
- Option 2 – \$71.20 per month

Oklahoma

- Option 1 – \$34.30 per month
- Option 2 – \$73.70 per month

Oregon/Washington

- Option 1 – \$35.80 per month
- Option 2 – \$82.30 per month

Pennsylvania/West Virginia

- Option 1 – \$34.50 per month
- Option 2 – \$69.00 per month

South Carolina

- Option 1 – \$31.00 per month
- Option 2 – \$66.30 per month

Texas

- Option 1 – \$31.30 per month
- Option 2 – \$86.30 per month

**Upper Midwest/Northern Plains:
(Iowa/Minnesota/Montana/Nebraska/
North Dakota/ South Dakota/Wyoming)**

- Option 1 – \$50.60 per month
- Option 2 – \$75.30 per month

Virginia

- Option 1 – \$33.00 per month
- Option 2 – \$69.00 per month

Wisconsin

- Option 1 – \$36.90 per month
- Option 2 – \$75.80 per month

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (__/__/____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):


Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____

Phone Number: _____ **Relationship to You** _____

E-mail Address: _____

Please Provide Your Medicare Insurance Information

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	 <p>SAMPLE ONLY</p> <p>Name: _____</p> <p>Medicare Claim Number _____ Sex _____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To _____ Effective Date _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>
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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 (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Health Net Orange (PDP).

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a bill
- Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Savings
- Automatic deduction from your monthly Social Security/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 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 Health Net Orange? 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. 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): _____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

Spanish Large Print Braille

Please contact Health Net Orange at 1-800-865-9431 if you need information in another format or language than what is listed above. TTY users should call 1-800-929-9955. Our office hours are 8:00 a.m.–8:00 p.m., 7 days a week.



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 Health Net Orange, 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 Health Net Orange could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Net Orange. 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 Below:

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

Health Net Orange 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 Health Net Orange 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 Health Net Orange 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.

Health Net Orange serves a specific service area. If I move out of the area that Health Net Orange 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 Health Net Orange network pharmacies. Once I am a member of Health Net Orange, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Orange when I get it 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 Health Net Orange, he/she may be paid based on my enrollment in Health Net Orange.

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 Health Net Orange will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Orange 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.

Signature: _____

Today's Date: _____

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

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee _____

Health Net Enrollment Office Use Only:

Effective Date of Coverage: _____ Plan/Group ID: _____

IEP: _____ AEP: _____ SEP (type): _____ Batch Number: _____

Application Date: _____

Health Net Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Broker Name: _____ Phone #: _____ ID# _____

Sales Rep Name: _____ Phone #: _____ ID# _____

FMO/GA/Agency Name: _____ Phone #: _____ ID# _____

Broker Email Address: _____

Producer Received Date: _____

6025706 PDP84222 (8/11)

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White Copy – Health Net Yellow Copy – Writing Agent Pink Copy – Member

Attestation of Eligibility for an Election Period

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) _____ .
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ .
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) _____ .
- 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) _____ .
- I recently left a PACE program on (insert date) _____ .
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____ .
- I am leaving employer or union coverage on (insert date) _____ .
- 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 making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date) _____ .

If none of these statements applies to you or you're not sure, please contact Health Net Orange at 1-800-865-9431 to see if you are eligible to enroll. We are open 8:00 a.m.–8:00 p.m., 7 days a week. TTY users should call 1-800-929-9955.