



Carefully read these instructions before filling out the application. Please complete the application using a ballpoint pen.

- 1. If possible, copy your Medicare Card.** Please make a copy of your Medicare card to include with the application. If you are unable to include a copy of the card, please be sure to complete the section on the first page related to your Medicare card.
- 2. Bank Draft Form.** If you would like to have your premiums withdrawn directly from your checking account, please complete the Authorization for Bank Draft Form.
- 3. Credit Card Form.** If you would like to pay your premium with your credit card, please call Member Services at 1-800-316-CARE (2273) (TTY users should call 1-800-848-0298) to request a form.
- 4. Mail your application.** After completing the application and the forms listed above, if applicable, please sign and return them to Windsor Rx.

**Windsor Health Plan, Inc.
Attn: Enrollment Applications
7100 Commerce Way Suite 285
Brentwood, TN 37027**

Confirmation of Eligibility by Medicare (Centers for Medicare & Medicaid Services or CMS)

After we receive your completed application the necessary information will be sent to CMS, the governmental agency that administers Medicare. One copy of this application will be returned to you. Once your eligibility has been verified and confirmed by CMS we will notify you in writing about the status of your application.

**Thank you.
Windsor Rx**

Windsor Rx is a product of Windsor Health Plan, Inc.,
a Medicare Advantage organization with a Medicare contract.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between November 15 and December 31 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. *When?* _____
- I recently moved and this plan is a new option for me. *When?* _____
- I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). *When?* _____
- I recently left a PACE program. *When?* _____
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). *When?* _____
- I am leaving employer or union coverage. *When?* _____
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. *When?* _____
- None of these statements apply to me.*

*Please contact Windsor Rx at 1-800-316-CARE (2273) (TTY users should call 1-800-848-0298) to see if you are eligible to enroll. We are open 7 a.m. - 8 p.m. Central, seven days a week.

To enroll in a Windsor Rx Plan, please provide the following information:

Please check which plan you want to enroll in:

- Windsor Rx Plan - Tennessee / Alabama (001)..... \$28.20
- Windsor Rx Plan - Mississippi (005)..... \$28.20
- Windsor Rx Plan - Arkansas (003) \$28.20
- Windsor Rx Plan - South Carolina (007) \$28.20

FIRST Name: _____ LAST Name: _____ Middle Initial: _____

Birth Date MM/DD/YYYY: _____/_____/_____ Sex: Male Female (Optional) Social Security Number: _____-_____-_____ Home Phone Number: (____)____-_____

Permanent Residence Street Address: _____ County: _____

City: _____ State: _____ ZIP Code: _____


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

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

E-mail Address: _____

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 red, white and blue Medicare card
 - or -
 - Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.
- You Must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.**

MEDICARE			HEALTH INSURANCE	
Name _____				
Medicare Claim Number _____			Sex _____	
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

Paying your plan premium

You can pay your monthly plan premium by mail, bank draft or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

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 does not 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.
- Draft your bank account each month. Complete the Authorization for Bank Draft form.
- Credit Card. Please complete Credit Card Authorization form. Call 1-800-316-CARE (2273) to request a form.
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include ALL premiums due from your enrollment effective date up to the point withholding begins.) _____ **initials**

Please read and answer these important 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 Windsor 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. 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 us to send you information in another format: Large Print Audio tape

Please contact Windsor Rx at 1-800-316-CARE (2273) (TTY users should call 1-800-848-0298) if you need information in another format or language than what is listed above. Our office hours are 7 a.m. - 8 p.m. Central, seven 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 a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Windsor 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 Windsor Rx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Windsor Rx may change how your current coverage works. 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 is no 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:**

Windsor 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 coverage. It is my responsibility to inform Windsor 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 Windsor 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 (November 15 – December 31), unless I qualify for certain special circumstances.

Windsor Rx serves a specific service area. If I move out of the area that Windsor 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 to access Windsor Rx benefits, except under limited, non-routine circumstances when I cannot reasonably use Windsor Rx network pharmacies. Once I am a member of Windsor 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 Windsor Rx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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.

By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Windsor Rx, he/she may be compensated based on my enrollment in Windsor 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 and concerning 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 Windsor Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Windsor 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 behalf of the individual under the laws of the State where the individual resides) 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 Windsor Rx or by Medicare.

As a Windsor Rx member, I grant the plan permission to use my name in marketing. Yes No _____ **initials**

Signature: _____ **Today's Date:** _____

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

Name: _____ Relationship to Enrollee: _____

Phone Number: _____ Address: _____

Office Use Only:

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

Effective Date of Coverage: ____/____/____ ICEP/IEP: OEP: AEP: SEP (type): _____

Seminar In-Home SG CG OG TE PC PM

Agent ID#: _____ Agent Signature: _____ Date: ____/____/____