



**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 Bank Draft Form.** If you would like to have your premiums withdrawn directly from your checking account, please complete the Authorization for Bank Draft Form.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 Customer Service at 1-800-316-2273 (TTY users should call 1-866-460-7617) 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. When mailing an application, Windsor Rx will determine your effective date based on the date Windsor Rx receives your application.

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

- 5. Verification Phone Call.** Within five business days of receiving your application at Windsor Medicare Extra, we will make three attempts to reach you by phone. The purpose of this call is to verify the information you provided on this application is correct and to confirm your understanding of our plan rules. Please provide the verification call phone number if it differs from the phone numbers requested on this enrollment application.

**Confirmation of Eligibility by Medicare (Centers for Medicare & Medicaid Services (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 (PDP)**

**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 or I recently moved and this plan is a new option for me. I moved 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.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- None of these statements applies to me.\*

\*Please contact Windsor Rx at 1-800-316-2273 to see if you are eligible to enroll. We are open 7 a.m. - 8 p.m. Central Time, seven days a week. (TTY users should call 1-866-460-7617).

Please contact Windsor Rx if you need information in another language or format (Braille).

**To Enroll in Windsor Rx, Please Provide the Following Information:**

Please check which plan you want to enroll in:

- Windsor Rx Plan (PDP)-Tennessee / Alabama (001) .... \$25.10 monthly
- Windsor Rx Plan (PDP)-Mississippi (005) ..... \$19.90 monthly
- Windsor Rx Plan (PDP)-Arkansas (003).....\$14.20 monthly
- Windsor Rx Plan (PDP)-South Carolina (007)... \$32.40 monthly

LAST Name:		FIRST Name:		Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date (MM/DD/YYYY) (____/____/____)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: (____)____-____		Verification Number (if different): (____)____-____	
Permanent Residence Street Address (P.O. Box is not allowed):				County:	
City:		State:		ZIP Code:	

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

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**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 the 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 benefit check each month.**

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](http://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.
- Draft your bank account each month. Complete the Authorization for Bank Draft form.
- Credit Card. Please complete Credit Card Authorization form. Call 1-800-316-2273 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.)

**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 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 that we send you information in a language other than English or in another format:**

- Large Print  Audio tape

Please contact Windsor Rx at 1-800-316-2273 if you need information in another format or language than what is listed above. TTY users should call 1-866-460-7617. Our office hours are 7 a.m. - 8 p.m. Central Time, 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 coverage 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 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 Windsor Rx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Windsor 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 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 Part A or Part B 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 except in an emergency 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 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 Windsor Rx, he/she may be paid 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, 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 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 Windsor Rx or 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:** \_\_\_\_\_

**Medicare Prescription Drug Plan 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

Agent ID#: \_\_\_\_\_ Agent Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_