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TEAMSTAR® MEDICARE PART D PRESCRIPTION DRUG PROGRAM (PDP) ENROLLMENT FORM

ADMINISTERED BY UNITED AMERICAN INSURANCE COMPANY, McKINNEY, TEXAS

Personal Offer Code: RDRCDNLD01

PLEASE SELECT PLAN

○ **Bronze** Plan	Monthly Direct Bill: $39 Monthly Bank Draft: $38	
○ **Silver** Plan	Monthly Direct Bill: $77 Monthly Bank Draft: $76	
○ **Platinum** Plan	Monthly Direct Bill: $138 Monthly Bank Draft: $137	

PLEASE PROVIDE INFORMATION ABOUT YOU. PLEASE PRINT CLEARLY

First Name	Middle	Last Name	Email Address
Permanent Residence Address			☐ Mr. ☐ Mrs. ☐ Ms.
City	State	Zip	Home Phone Number ( )
Mailing Address (only if different from your Permanent Residence Address)			SEX ☐ M ☐ F
City	State	Zip	Birth Date _____ _____ _____ (MM) (DD) (YYYY)

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 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 _____

Medicare Number Sex _____

__ __ __-__ __-__ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

PAYING YOUR PLAN PREMIUM

You can pay your monthly premium (including any late enrollment penalty you may owe) by mail (direct bill) or by bank draft. If you are assessed a Part D-Income Related Monthly Adjustment Amount by Medicare (Part D-IRMAA), you will be notified by the Social Security Administration and you will be responsible for paying this extra amount to Medicare. Please do not send any payments for Part D-IRMAA to TEAMStar® Part D.

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 premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and do not 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 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 Medicare does not cover.

SELECT YOUR PAYMENT OPTION ON THE NEXT PAGE

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PLEASE SELECT A PREMIUM PAYMENT OPTION

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

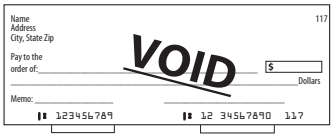
- ○ **I would like my Medicare prescription drug plan premiums deducted monthly from my checking account (Monthly Bank Draft).** (Please complete authorization below.)
- ○ **I want to be billed monthly (Direct Bill).**

If you wish to pay by Automatic Bank Draft and save an additional $1.00 per payment, please complete the form below.

"AUTOMATIC" PAYMENT PLAN AUTHORIZATION

Please tape a personalized voided check. DO NOT STAPLE.

AUTOMATIC PAYMENT PLAN AUTHORIZATION: I authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United American Insurance Company. This authorization is to remain in effect until revoked by me in writing. All premiums/fees may be automatically withdrawn from my account on a MONTHLY basis.



Bank Routing Number | Bank Account Number

NOTE: If Draft Day selected is the 18th or greater, your Part D premium will draft in the month prior to your due date.

Bank Draft Day ☐☐ *Day of the month you want your account to be drafted – 01 to 28 only.*

Account Holder's Signature (as it appears on financial institution records)

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits insurance coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to TEAMStar® Medicare Part D? ○ YES ○ NO
   If "YES", please list your other coverage and your identification (ID) number(s):

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? If "YES", please provide the following information: ○ YES ○ NO

Name of Institution:

Address	Phone Number

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 TEAMStar® Medicare Part D, 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 TEAMStar® Medicare Part D could affect your employer or union health benefits. You could lose your employer or union health coverage if you join TEAMStar® Medicare Part D. 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.

BE SURE TO SIGN AND DATE THE ENROLLMENT FORM ON THE NEXT PAGE

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PLEASE READ AND SIGN BELOW

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

TEAMStar® Medicare Part D Prescription Drug Program (PDP) 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 TEAMStar® Medicare Part D 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 TEAMStar® Medicare Part D will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to TEAMStar® Medicare Part D or by calling 1-800-MEDICARE, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use TEAMStar® Medicare Part D network pharmacies. Once I am a member of TEAMStar® Medicare Part D, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from TEAMStar® Medicare Part D 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. 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 TEAMStar® Medicare Part D will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that TEAMStar® Medicare Part D 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 TEAMStar® Medicare Part D or by Medicare.

SIGNATURE	Today's Date	Affiliated with IBT Local #:

IF YOU ARE THE AUTHORIZED REPRESENTATIVE, YOU MUST SIGN ABOVE AND PROVIDE THE FOLLOWING INFORMATION:

Name : _____

Address : _____

Phone Number: (_____)_____-_____ Relationship to Enrollee: _____