OMB No. 0938-1378
Expires: 07/31/2024

Individual enrollment request form to enroll in a Medicare Prescription Drug Plan (Part D)

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–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 in Section 1. The items in Section 2 are optional — 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.
- We 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.

What happens next?

Send your completed and signed form to:
Cigna Medicare Prescription Drug Plans
P.O. Box 269005
Weston, FL 33326-9927

Or fax to this **PDP** number: **1-800-735-1469**. Once we process your request to join, we will contact you.

How do I get help with this form?

Call Cigna Healthcare℠ at 1-800-735-1459. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Cigna Healthcare al Cigna Healthcare al 1-800-735-1459/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

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

Cigna Healthcare Medicare Prescription Drug Plan
2024 Individual Enrollment Form

Section 1 – All fields on this page are required (unless marked optional)

To Enroll in Cigna Healthcare Medicare Prescription Drug Plan, Please Provide the Following Information:

Please check which plan you want to enroll in:	☐ **Cigna Saver Rx (PDP)** ☐ **Cigna Extra Rx (PDP)**	☐ **Cigna Secure Rx (PDP)**

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

Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Phone numbers to contact you: Primary number (__ __ __) __ __ __ - __ __ __ __ ☐Home ☐Cell Alternate number (optional) (__ __ __) __ __ __ - __ __ __ __ ☐Home ☐Cell

To receive email communications provide your email address below. To update your communication preferences visit **myCigna.com**
Your Email Address (optional):

Permanent Residence Street Address (P.O. Box is not allowed):

City:	State:	ZIP Code:

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

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

Emergency Contact (optional):	Phone Number:	Relationship to You:

Please Provide Your Medicare Insurance Information:

Medicare number _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Cigna Healthcare Medicare Prescription Drug Plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

IMPORTANT: Read and sign below:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Cigna Medicare Prescription Drug Plan.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Cigna Healthcare will share my information with Medicare, who may use it to track my enrollment, to make payments, and other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I understand that I can be enrolled in only one MA or Part D plan at a time—and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the 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.

IMPORTANT: Read and sign below (continued):

- 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.
- Cigna Healthcare Medicare Prescription Drug Plan serves a specific service area. If I move out of the area that Cigna Healthcare Medicare Prescription Plan 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 Cigna Healthcare Medicare Prescription Drug Plan network pharmacies.
- 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.

By signing below and providing my phone number, I agree that Cigna Healthcare, its affiliates, and representatives may contact me regarding additional products or services by calling or texting me at the number listed. I acknowledge these messages may be delivered using an automatic telephone dialing system and/or an artificial or prerecorded voice. I agree that Cigna Healthcare may use the information provided or obtained in connection with this application, or insurance coverage provided by Cigna Healthcare including my personal information, to offer me additional products and services or to send related marketing communications regarding Cigna Healthcare products. I acknowledge that I am not required to provide consent to receive these communications as a condition of applying for coverage. If I choose not to receive marketing communications, I will indicate that below or can withdraw my consent at any time by contacting Cigna Healthcare.

☐ I do not consent to receive marketing communications at this number.

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 _____

Attestation of Eligibility for an Enrollment Period
Skip this section if you are enrolling between October 15 – December 7

Please complete – if you are enrolling outside of October 15 – December 7.

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) or I get Extra Help, but I haven't had a change.

☐ 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) _____.

Attestation of Eligibility for an Enrollment Period
Skip this section if you are enrolling between October 15 – December 7 (Continued)

- ☐ 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 recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly received, had a change, or lost Extra Help) on (insert date) _____.
- ☐ 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) _____.
- ☐ I recently had a change in my Medicaid (newly received, had a change, or lost Medicaid) on (insert date) _____.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (Jan 1 -March 31)
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Cigna Healthcare Medicare Prescription Drug Plan at 1-800-735-1459 (TTY 711) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m. local Time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – Sept. 30.

Section 2 – All fields that follow below are optional

Answering these questions is your choice. You can't be denied coverage because you didn'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? Select all that apply. ☐ 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.

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White ☐ **I choose not to answer.**

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 ☐ Braille

Please contact Cigna Healthcare Medicare Prescription Drug Plan at 1-800-735-1459 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. – 8 p.m. local Time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – Sept. 30. TTY users can call 711.

Paying Your Plan Premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, Electronic Funds Transfer (EFT), or credit card 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 Cigna Healthcare Medicare Prescription Drug Plan.

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.ssa.gov/medicare/part-d-extra-help.

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

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check. (Depending on the date your enrollment is processed, you may receive a premium invoice for the first month you are enrolled. If Social Security/Railroad Retirement Board accepts your request for deduction, the deduction from your benefit check may take several months to take effect. Therefore, your first deduction may include the premiums for several months. 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.)

I get monthly benefits from: ☐ Social Security ☐ RRB

After Medicare has approved your enrollment, you will have additional payment options to choose from.
Visit **Cigna.com/PartDPremiumPayment** for online payment options and details.

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____ Effective Date of Coverage:_____ IEP: _____ AEP: _____

SEP (Type): _____

Name of Plan Representative/Agent/Broker: _____

Producer Use Only:

The person that is discussing plan options with you is either employed by or contracted directly or indirectly with Cigna Healthcare. The person may be compensated based on your enrollment in a plan.

Producer Last Name: _____ Producer First Name: _____

Cigna Healthcare Agent ID: _____ Producer License Number*: _____

Producer Agency: _____

Producer must provide how the enrollment was completed:

☐ Face-to-face meeting ☐ Walk-in ☐ Sales event ☐ Through mail ☐ Telephone

Producer Signature: _____ Date: _____

Producer Phone: (__ __ __) __ __ __ - __ __ __ __ Producer E-mail: _____

Producer needs to provide Effective Date requested, IEP, AEP, or SEP information above. Please be sure to sign and date the form.

* License Number in State where policy was sold.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.