

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](https://www.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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

- Your plan 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:

Arkansas Blue Medicare
P.O. Box 3648
Little Rock, AR 72203

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Arkansas Blue Medicare at

1-855-591-9794. 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 Arkansas Blue Medicare al **1-855-591-9794**/TTY **711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para 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.

2025 Prescription Drug Plan Enrollment Form



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

Select the plan you want to join:

Arkansas Blue Medicare prescription drug plans are available in every county in Arkansas.

002	BlueMedicare Premier Rx (PDP)	\$158.90
003	BlueMedicare Value Rx (PDP)	\$48.90

First name		Last name			Middle initial
Birth date (MM/DD/YYYY) (/ /)	Sex M F	Phone number () -			
Permanent residence street address (don't enter a P.O. Box)	City	County	State	ZIP code	
Mailing address, if different from your permanent address (P.O. Box allowed) Street address	City	State	ZIP code		

Your Medicare information:

Medicare number

- -

Medicare Part A effective date (MM/DD/YYYY)

Medicare Part B effective date (MM/DD/YYYY)

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Arkansas Blue Medicare?

Yes No

Name of other coverage	Member number for this coverage	Group number for this coverage
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IMPORTANT - Read and sign below:

- I must keep hospital (Part A) or medical (Part B) to stay in Arkansas Blue Medicare.
- By joining this Medicare prescription drug plan, I acknowledge that Arkansas Blue Medicare will release my information to Medicare, who may use it to track beneficiary enrollment, for payment, and other purposes applicable to federal statutes that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D 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.
- 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.

Signature

Today's date

If you're the authorized representative, sign above and fill out these fields:

Name

Address

Phone number

Relationship to enrollee

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. There are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of this 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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).	
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	
I recently was released from incarceration. I was released on	
I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on	
I recently obtained lawful presence status in the United States. I got this status on	
I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on	
I recently had a change in my "Extra Help" paying for Medicare prescription drug coverage (newly got "Extra Help," had a change in the level of "Extra Help," or lost "Extra Help") on	
I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get "Extra Help" paying for my Medicare prescription drug coverage, but I haven't had a change.	
I am moving into, 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	
I recently left a PACE program on	
I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on	
I am leaving employer or union coverage on	
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 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	

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.

I dropped a Medicare Supplement insurance (Medigap) policy when I first joined a Medicare Advantage plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I'm joining a drug plan (Part D).

I joined a Medicare Advantage plan with drug coverage when I turned 65. It's been less than 12 months since I joined this plan. I want to switch to Original Medicare, and I'm joining a drug plan.

If none of these statements applies to you or you're not sure, please contact Arkansas Blue Medicare at **1-855-591-9794** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. - 8 p.m. Central, seven days a week, from October 1 - March 31, except for Thanksgiving and Christmas. From April 1 - September 30, our hours are 8 a.m. - 8 p.m. Central, five days a week.

Section 2 - All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don'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
- Yes, Puerto Rican
- Yes, another Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, or Chicano/a
- Yes, Cuban

I choose not to answer.

What's your race? Select all that apply.

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

What is your gender? Select one.

- Woman Man Non-binary I use a different term _____
- I choose not to answer

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay Straight, that is, not gay or lesbian Bisexual
- I use a different term _____ I don't know **I choose not to answer**

Select one if you want us to send you information in an accessible format.

- Large print Audio format Data format Other format

Please contact Arkansas Blue Medicare at **1-855-591-9794** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. - 8 p.m. Central, seven days a week, from October 1 - March 31, except for Thanksgiving and Christmas. From April 1 - September 30, our hours are 8 a.m. - 8 p.m. Central, five days a week. TTY users should call **711**.

Do you work?

- Yes No

Does your spouse work?

- Yes No



List your primary care physician (PCP), clinic, or health center

I want to get the following materials via email

- Annual member materials



Email address

Important plan documents are available for download at arkbluemedicare.com.

Paying your plan premium

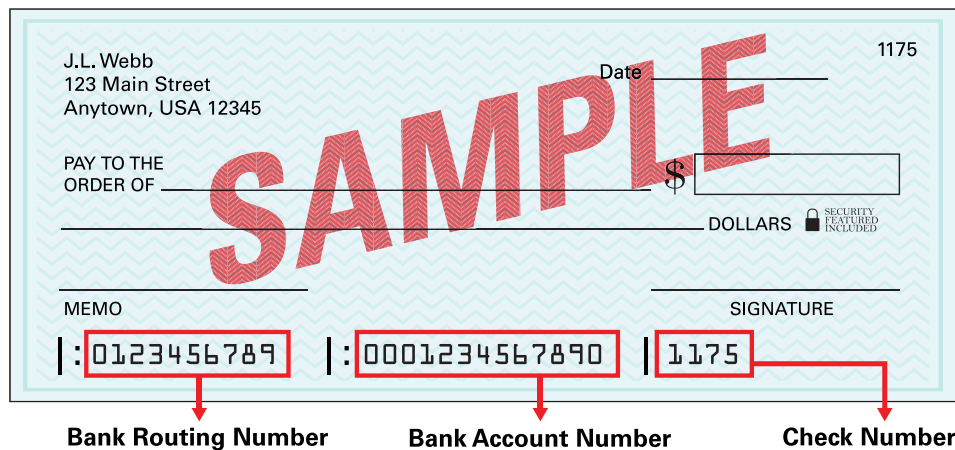
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or electronic funds transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DO NOT** pay Arkansas Blue Medicare the Part D-IRMAA.

Please select a premium payment option

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Bank routing number	Bank account number	Account type
		Checking Savings



Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit

I get monthly benefits from:

Social Security RRB

Get monthly bill

Please mail your completed and signed enrollment form to Arkansas Blue Medicare using the postage paid business reply envelope included.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National producer number (Agents/Brokers only)

Office Use Only

**Arkansas Blue Medicare/Authorized agent
(individual sales representative/agent who completed the application)**

Agent type (select one): Authorized agent ABM employee

Sales rep/Agent name	Sales rep/Agent NPN #	Agent ID #
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Enrollment type: In-person Over-the-phone

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or prescription drug plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.