

SERFF Tracking Number: ARBB-127730650 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50045
Company Tracking Number: 10-104GRPTEPDP 11/11, 10-04RETG R11/11
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Applications
Project Name/Number: Employer Application, Retiree Application/10-104GRPTEPDP 11/11, 10-04RETG R11/11

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Applications

SERFF Tr Num: ARBB-127730650 State: Arkansas

TOI: MS06 Medicare Supplement - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 50045

Sub-TOI: MS06.000 Medicare Supplement -
Other

Co Tr Num: 10-104GRPTEPDP State Status: Approved-Closed
11/11, 10-04RETG R11/11

Filing Type: Form

Authors: Christi Kittler, Yvonne
McNaughton, Frank Sewall, Rita
Thatcher, Evelyn Laney

Reviewer(s): Stephanie Fowler
Disposition Date: 10/21/2011

Date Submitted: 10/18/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Employer Application, Retiree Application

Status of Filing in Domicile: Pending

Project Number: 10-104GRPTEPDP 11/11, 10-04RETG R11/11

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Arkansas is state
of domicile.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 10/21/2011

State Status Changed: 10/21/2011

Deemer Date:

Created By: Evelyn Laney

Submitted By: Evelyn Laney

Corresponding Filing Tracking Number:

Filing Description:

Attached please find Change 10-104GRPTEPDP 11/11 and 10-04RETG R11/11 for your review and approval if indicated.

Form 10-104GRPTEPDP 11/11 provides Medi-Pak prescription drug benefits. Form 10-104RETG R11/11 is amended to include the option for Medi-Pak prescription drug benefits.

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further

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certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the policies to which these amendments are attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
 320 West Capitol, Ste 211 501-378-2165 [Phone]
 Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$100.00	10/18/2011	52927714

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	10/21/2011	10/21/2011

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Disposition

Disposition Date: 10/21/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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 Company Tracking Number: 10-104GRPREDPDP 11/11, 10-04RETG R11/11
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
 Product Name: Applications
 Project Name/Number: Employer Application, Retiree Application/10-104GRPREDPDP 11/11, 10-04RETG R11/11

Form Schedule

Lead Form Number: 10-104GRPREDPDP 11/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	10-104GRPREDPDP 11/11	Application/Enrollment	Application/TPDP Form	Initial			10-104GRPREDPDP 11-11.pdf
Approved-Closed	10-04RETG R11/11	Application/Enrollment	Application/R11/11 Form	Revised	Replaced Form #: 10-04RETG R11/11 Previous Filing #: 10-04RETG 1/10		10-04RETG R11-11retiree app.pdf



APPLICATION by:

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee Medicare Prescription Drug benefit plan (the "Plan") for the Policyholder's retirees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's retirees.

SECTION 1. GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

SECTION 2. POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

SECTION 3. BENEFIT SELECTION

RETIREE MEDI-PAK® Rx GROUP BENEFITS

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Class	Class Description	Contribution		
		Retiree	% Dependent	%

Note: The Employer must pay a minimum of 50% of the retiree's premium. This Policy may be terminated by the Company if the Policyholder fails to contribute the percentage of premium specified above.

	Option 1	Option 2
Deductible		
Annual Deductible	_____	_____
Initial Coverage Period		
Generic drugs (34-day supply)	_____	_____
Preferred brand drugs (34-day supply)	_____	_____
Non-preferred brand drugs (34-day supply)	_____	_____
Specialty drugs (34-day supply)	_____	_____
Gap Coverage		
Generic drugs (34-day supply)	_____	_____
Preferred brand drugs (34-day supply)	_____	_____
Non-preferred brand drugs (34-day supply)	_____	_____
Specialty drugs (34-day supply)	_____	_____
Catastrophic Coverage		
Generic drugs (34-day supply)	_____	_____
Brand drugs (34-day supply)	_____	_____
Formulary		
90-day supply	_____	_____

Rates

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

SECTION 4. ATTESTATIONS

There are a number of federal regulations that impact Medicare Prescription Drug group plans. Policyholder agrees to comply with all applicable Medicare Prescription regulations, specifically including Chapter 3, Enrollment, Eligibility and Disenrollment of the Medicare Prescription Drug Internet Only Manual.

Policyholder agrees to reduce up-front the premium contribution required for those retirees or dependents that are eligible for Low-Income Subsidy. If Group plan is not able to reduce up-front the premiums paid by the retiree/dependent, the group plan agrees to directly refund the amount of the low-income premium subsidy up to the monthly premium contribution previously collected from the retiree/dependent. The refund must be completed within 45 days of CMS payment to Arkansas Blue Cross.

SECTION 5. RETIREE / DEPENDENT INFORMATION, MINIMUM NUMBER OF INSURED RETIREES / DEPENDENTS & MINIMUM PARTICIPATION REQUIREMENTS.

	In State	OUT OF STATE	TOTAL
Total Number of Retirees and Dependents			

Minimum Number of Insured Retirees and Dependents. To meet group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. A group must maintain 25 enrolled Retirees and Dependents to remain active in the plan.

This Policy may be terminated by the Company if the number of insured Retirees and Dependents fall below the minimum number of insured Retirees and Dependents specified above.

SECTION 6. SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20____
(City, State)

_____ [full legal name of Policyholder]

By:

 Authorized Signature

 Printed Name

 Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the individual applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its retirees including the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

 Agent Signature

 Insurance License #/Agency Fed. Tax ID#

 Agent Printed Name

 Date



Please check the appropriate box and fill in blanks below in ink.

Group No.:

I.D. No.:

- Retiree Medi-Pak Group Coverage
- Medi-Pak Rx Group (PDP) - Standard
- Medi-Pak Rx Group (PDP) - Enhanced

FOR OFFICE USE ONLY

- Retiree
 - Spouse
 - Disabled Dependent
- Retirement Date: _____

COBRA Effective Date

COBRA Termination Date

Reason for COBRA:

Mo.

Day

Year

Mo.

Day

Year

SECTION 1. APPLICANT INFORMATION

First Name:

Middle Name:

Last Name:

Residential Address:

City:

State:

Zip Code:

Mailing Address:

City:

State:

Zip Code:

Home Phone No.

Alternate Phone No.

Social Security Number

Birth Date (mm/dd/yyyy)

Gender (F/M)

Medicare Health Identification Contract (HIC) Number

Medicare part A Effective Date

Medicare Part B Effective Date

SECTION 3. OTHER MEDICAL INSURANCE

Will you, your spouse or your disabled dependent be continuing any other health insurance coverage, including Medicare?
 You Yes No Spouse Yes No Disabled Dependent Yes No

Name of Insurance:

Member ID #:

Group Number:

Does this insurance include prescription drug coverage? Yes No

SECTION 4. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

Important Information if you are enrolling in Medi-Pak Group Rx

Medi-Pak Group Rx is a Medicare drug plan and has a contract with the Federal government. 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 Medi-Pak Group Rx will end that enrollment. 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.

Release of information

By joining this Medicare prescription drug plan, I acknowledge that Medi-Pak Group Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medi-Pak Rx Group will release my information, including prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

SECTION 4. SIGNATURES (Cont'd)

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

I understand that the benefits for which I (we) will be eligible are those described in the Retiree Medi-Pak Group Policy and Medi-Pak Group Rx Evidence of Coverage and may from time to time be changed. I understand that coverage will not become effective before the approved effective date. I understand that this coverage is in addition to my coverage under Medicare; therefore, I must keep my Medicare Part A and Part B coverage. I understand that it is my responsibility to inform Arkansas Blue Cross of any medical or prescription drug coverage that I have or may get in the future.

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 Arkansas Blue Cross or Medicare.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Applicant

Signature of Applicant

Date

Print Employer/Group Administrator*

Signature Employer/Group Administrator*

Date

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

Name:

Address:

Phone Number:

Relationship to Enrollee:

Note: An applicant's authorized representative must supply a copy of the applicant's durable power of attorney appointing the authorized representative the applicant's attorney in fact for Retiree Medi-Pak Group coverage.

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification		
Bypass Reason: Not required.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: See attached.		
Attachments: 10-104GRPREDPDP 11- 11.pdf 10-04RETG R11-11retiree app.pdf		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification		
Bypass Reason: Not required.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage		
Bypass Reason: Not required.		
Comments:		



APPLICATION by:

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee Medicare Prescription Drug benefit plan (the "Plan") for the Policyholder's retirees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's retirees.

SECTION 1. GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

SECTION 2. POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

SECTION 3. BENEFIT SELECTION

RETIREE MEDI-PAK® Rx GROUP BENEFITS

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Class	Class Description	Contribution		
		Retiree	% Dependent	%

Note: The Employer must pay a minimum of 50% of the retiree's premium. This Policy may be terminated by the Company if the Policyholder fails to contribute the percentage of premium specified above.

	Option 1	Option 2
Deductible		
Annual Deductible	_____	_____
Initial Coverage Period		
Generic drugs (34-day supply)	_____	_____
Preferred brand drugs (34-day supply)	_____	_____
Non-preferred brand drugs (34-day supply)	_____	_____
Specialty drugs (34-day supply)	_____	_____
Gap Coverage		
Generic drugs (34-day supply)	_____	_____
Preferred brand drugs (34-day supply)	_____	_____
Non-preferred brand drugs (34-day supply)	_____	_____
Specialty drugs (34-day supply)	_____	_____
Catastrophic Coverage		
Generic drugs (34-day supply)	_____	_____
Brand drugs (34-day supply)	_____	_____
Formulary		
90-day supply	_____	_____

Rates

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

SECTION 4. ATTESTATIONS

There are a number of federal regulations that impact Medicare Prescription Drug group plans. Policyholder agrees to comply with all applicable Medicare Prescription regulations, specifically including Chapter 3, Enrollment, Eligibility and Disenrollment of the Medicare Prescription Drug Internet Only Manual.

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SECTION 5. RETIREE / DEPENDENT INFORMATION, MINIMUM NUMBER OF INSURED RETIREES / DEPENDENTS & MINIMUM PARTICIPATION REQUIREMENTS.

	In State	OUT OF STATE	TOTAL
Total Number of Retirees and Dependents			

Minimum Number of Insured Retirees and Dependents. To meet group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. A group must maintain 25 enrolled Retirees and Dependents to remain active in the plan.

This Policy may be terminated by the Company if the number of insured Retirees and Dependents fall below the minimum number of insured Retirees and Dependents specified above.

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This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20____
(City, State)

_____ [full legal name of Policyholder]

By:

_____ Authorized Signature

_____ Printed Name

_____ Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the individual applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its retirees including the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

_____ Agent Signature

_____ Insurance License #/Agency Fed. Tax ID#

_____ Agent Printed Name

_____ Date



Please check the appropriate box and fill in blanks below in ink.

Group No.:

I.D. No.:

- Retiree Medi-Pak Group Coverage
- Medi-Pak Rx Group (PDP) - Standard
- Medi-Pak Rx Group (PDP) - Enhanced

FOR OFFICE USE ONLY

- Retiree
 - Spouse
 - Disabled Dependent
- Retirement Date: _____

COBRA Effective Date

COBRA Termination Date

Reason for COBRA:

Mo.

Day

Year

Mo.

Day

Year

SECTION 1. APPLICANT INFORMATION

First Name:

Middle Name:

Last Name:

Residential Address:

City:

State:

Zip Code:

Mailing Address:

City:

State:

Zip Code:

Home Phone No.

Alternate Phone No.

Social Security Number

Birth Date (mm/dd/yyyy)

Gender (F/M)

Medicare Health Identification Contract (HIC) Number

Medicare part A Effective Date

Medicare Part B Effective Date

SECTION 3. OTHER MEDICAL INSURANCE

Will you, your spouse or your disabled dependent be continuing any other health insurance coverage, including Medicare?
 You Yes No Spouse Yes No Disabled Dependent Yes No

Name of Insurance:

Member ID #:

Group Number:

Does this insurance include prescription drug coverage? Yes No

SECTION 4. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

Important Information if you are enrolling in Medi-Pak Group Rx

Medi-Pak Group Rx is a Medicare drug plan and has a contract with the Federal government. 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 Medi-Pak Group Rx will end that enrollment. 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.

Release of information

By joining this Medicare prescription drug plan, I acknowledge that Medi-Pak Group Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medi-Pak Rx Group will release my information, including prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

SECTION 4. SIGNATURES (Cont'd)

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

I understand that the benefits for which I (we) will be eligible are those described in the Retiree Medi-Pak Group Policy and Medi-Pak Group Rx Evidence of Coverage and may from time to time be changed. I understand that coverage will not become effective before the approved effective date. I understand that this coverage is in addition to my coverage under Medicare; therefore, I must keep my Medicare Part A and Part B coverage. I understand that it is my responsibility to inform Arkansas Blue Cross of any medical or prescription drug coverage that I have or may get in the future.

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 Arkansas Blue Cross or Medicare.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Applicant

Signature of Applicant

Date

Print Employer/Group Administrator*

Signature Employer/Group Administrator*

Date

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

Name:

Address:

Phone Number:

Relationship to Enrollee:

Note: An applicant's authorized representative must supply a copy of the applicant's durable power of attorney appointing the authorized representative the applicant's attorney in fact for Retiree Medi-Pak Group coverage.