Return Applications to:
Department of Human Resources
Rochester Institute of Technology
George Eastman Hall, 5th floor
8 Lomb Memorial Drive
Rochester, NY 14623-5604
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.

**Paying Your Plan Premium**

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.

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 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 Simply Prescriptions, 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 Simply Prescriptions could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Simply Prescriptions. 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.
By completing this enrollment application, I agree to the following:

Simply Prescriptions contracts with the Federal Government and is a PDP plan with a Medicare contract. Enrollment in Simply Prescriptions depends on contract renewal. 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 Simply Prescriptions 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 Simply Prescriptions 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 (October 15-December 7), unless I qualify for certain special circumstances.

Simply Prescriptions serves a specific service area. If I move out of the area that Simply Prescriptions 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 Simply Prescriptions network pharmacies. Once I am a member of Simply Prescriptions, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Simply Prescriptions 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 Simply Prescriptions, he/she may be paid based on my enrollment in Simply Prescriptions.

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 Simply Prescriptions will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Simply Prescriptions 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 Medicare.

Signature: ____________________________________________  Today’s Date: __________________

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

NAME: ____________________________________________  RELATIONSHIP TO ENROLLEE: ______________________
ADDRESS: ____________________________  PHONE NUMBER: (        )

Medicare Prescription Drug Plan Use Only:
Effective Date of Coverage: ____________  IEP: ____________  AEP: ____________  SEP (type): ____________
Name of Plan Representative/agent/broker (if assisted in enrollment): ____________________________________________
Not Eligible: ____________________________________________