Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: Tel: (818) 654-4548 Fax: (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. #226

Tarzana , CA 91356

By Fax 818-776-9865

We will be in contact with you upon receipt of your completed application.

If you have questions please contact our office at: (818)654-4548

UNICARE®

Thank you for your interest in UniCare MedicareRx Rewards.
Below are some tips to help you complete this enrollment form.

HOW TO APPLY FOR UNICARE MEDICARERx REWARDS

You are required to answer all of the questions of the enrollment form.

Please fill out this form carefully.
We will need your complete Medicare information in order to process your application.

- ✔ Have your Medicare card ready. The Medicare information you provide should match exactly how it appears on your Medicare card. You also have the option of attaching a copy of your Medicare card or your letter of verification from the Social Security Administration or Railroad Retirement Board.
- ✔ Print in ink.
- ✔ Sign and date the enrollment form.

Note: Each person must complete a separate enrollment form.

You must be entitled to Part A of Medicare and must continue to pay your Part B premium to remain eligible as a member of Freedom Blue. Eligibility for Medicare Parts A and B will be verified prior to enrollment. We cannot consider this enrollment form complete until we have obtained your most current Medicare information.

Sign and date the enrollment form.
By signing this enrollment form, you acknowledge that you have read and understand the requirements.

If you are unable to sign this application, a court-appointed legal guardian or person having General Durable Power of Attorney (GDPA) must sign this application.

After you have completed the enrollment form, please return the form to:

Oleg Skurskiy

18375 Ventura Blvd. # 226 Tarzana , CA 91356 or by Fax 818-776-9865

White - UniCare Copy **Yellow** - Agent Copy **Pink** - Customer Copy

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UniCare Medicare Prescription Drug Plan Individual Enrollment Form

UniCare MedicareRx Rewards

Step 1: Please provide information about you. (Please print clearly.)				
Last name	First name	MI	☐ Mr. ☐ Mrs. ☐ Ms.	
Permanent residence street address	City	State	ZIP code	
Social Security number (optional)	Date of birth _____ /_____ /_____	Sex ☐ Male ☐ Female	Home phone number ( )	
Mailing address (only if different from your permanent residence address)				
Street/P.O. Box	City	State	ZIP code	

Step 2: For monthly premiums see attached rate sheet. Check the plan you wish to enroll in, choose only one.

☐ UniCare MedicareRx Rewards Value ☐ UniCare MedicareRx Rewards Plus ☐ UniCare MedicareRx Rewards Premier

Step 3: 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name _____

Medicare Claim Number Sex ____

__ __ __ - __ __ - __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Step 4: Please read this important information.

If you are in a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining UniCare MedicareRx , 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 and if your have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining UniCare MedicareRx could affect your employer or union health benefits.

If you have health coverage from an employer or union, joining UniCare MedicareRx may change how your current coverage works. 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 may be able to help.

S5960-2006-CO-239 7/20/2006

Step 5: Please select your plan premium payment option. *(You must check "Yes" or "No" below.)*

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail, or automatic withdrawal from your bank account. If you choose to make monthly payment by automatic withdrawal from your bank account, please complete the Automatic Payment Option form. Generally you must stay with the option you choose for the rest of the year.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the difference, if there is any, deducted from your monthly check.

Would you like the premium for this prescription drug plan deducted from your SSA monthly benefit check? ☐ **Yes** ☐ **No**

Note to applicants who qualify for extra help with their Medicare prescription drug plan premiums:
If you want to have any remaining premium you owe deducted from your monthly Social Security payment, please check "Yes" above.

Step 6: Please answer the following questions to help Medicare coordinate your benefits.

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to **UniCare MedicareR$_x$ Rewards**? . . . ☐ **Yes** ☐ **No**
If yes, please list your other coverage and your identification (ID) number for this coverage.

Name of other coverage _____

ID number _____ Group number _____

2. Are you a resident in a long-term care facility, such as a nursing home? . . . . . ☐ **Yes** ☐ **No**
If yes, please provide the following information.

Name of Institution _____

Address of Institution _____
Number and street City State ZIP code

Phone number of Institution (_____) _____

Step 7: Please read the information below and sign on the next page.

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

UniCare MedicareR$_x$ Rewards is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform **UniCare MedicareR$_x$ Rewards** 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. 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 **UniCare MedicareR$_x$ Rewards** or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

UniCare MedicareR$_x$ Rewards serves a specific service area. If I move out of the area that **UniCare MedicareR$_x$ Rewards** serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of **UniCare MedicareR$_x$ Rewards**, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from **UniCare MedicareR$_x$ Rewards** when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that **UniCare MedicareR$_x$ Rewards** will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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 behalf of the individual under the laws of the State where the individual resides) 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 **UniCare MedicareR$_x$ Rewards** or by Medicare.

Be sure to sign below:

I have read and understand the contents of this application, as indicated by my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I live). If signed by an authorized individual (as described above), this signature certifies that this person is authorized under State law to complete this enrollment. I understand that proof of the authorizatin (Durable Power of Attorney or Guardianship papers) must be attached this application.

Your Signature* _____ **Today's Date** _____

*If you are the authorized representative, you must provide the following information:

Name _____ Address _____

Phone number _____ Relationship to Enrollee _____

If anyone helped the individual fill out this form, he or she must sign below.

Signature _____ **Relationship** _____ **Date** _____

UNICARE PRODUCER/AGENT ONLY

1. I have reviewed the application with the applicant. I certify that the applicant is entitled to Part A and enrolled in Part B of Medicare.
2. I have assisted the applicant in filling out this application. ☐ **Yes** ☐ **No**

Agent Signature _____ Date _____

Print Agent's Name __Oleg Skurskiy_____ Agent Number __BCLNGNPVMZ_____

Appointment Set By (TM#)_____ Sub Agent Number _____

Street Address __18375 Ventura Blvd. # 226 _____ Telephone Number _818-654-4548_____

City_____Tarzana _____ State ___CA__ Zip_91356_____

Agency Name _____ Agency Tax ID Number _____

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Medicare Prescription Drug Plan Use Only:

Member ID # _____

Group number _____ PBP number _____

Effective Date of Coverage _____ IEP _____ AEP_____ SEP (type) _____

UniCare MedicareRx Rewards Value		UniCare MedicareRx Rewards Plus		UniCareMedicareRx Rewards Premier	
State	**Monthly Premium**	**State**	**Monthly Premium**	**State**	**Monthly Premium**
Alabama	$27.80	Alabama	$34.70	Alabama	$49.50
Alaska	$32	Alaska	$39	Alaska	$54.30
Arizona	$16.90	Arizona	$22.50	Arizona	$34.90
Arkansas	$30.50	Arkansas	$37.60	Arkansas	$52.80
California	$17.70	California	n/a	California	$36.20
Colorado	$21.40	Colorado	n/a	Colorado	$41.20
Connecticut	$22.10	Connecticut	n/a	Connecticut	$42.20
Delaware	$30.50	Delaware	$37.60	Delaware	$52.80
Florida	$23.10	Florida	$29.60	Florida	$43.50
Georgia	$33.10	Georgia	n/a	Georgia	$55.60
Hawaii	$21.40	Hawaii	$27.60	Hawaii	$41.20
Idaho	$26.20	Idaho	$32.90	Idaho	$47.40
Iowa	$19.40	Iowa	$21.50	Iowa	$33.40
Illinois	$30.50	Illinois	$37.60	Illinois	$52.80
Indiana	$23.10	Indiana	n/a	Indiana	$43.50
Kansas	$24.90	Kansas	n/a	Kansas	$45.80
Kentucky	$23.10	Kentucky	n/a	Kentucky	$43.50
Louisiana	$30.50	Louisiana	$37.60	Louisiana	$52.80
Maine	$25.10	Maine	n/a	Maine	$46.20
Maryland	$30.50	Maryland	$37.60	Maryland	$52.80
Massachusetts	$22.10	Massachusetts	n/a	Massachusetts	$42.20
Michigan	$32	Michigan	$39	Michigan	$54.30
Minnesota	$19.40	Minnesota	$21.50	Minnesota	$33.40
Mississippi	$32	Mississippi	$39	Mississippi	$54.30
Missouri	$23.10	Missouri	n/a	Missouri	$43.50
Montana	$19.40	Montana	$21.50	Montana	$33.40
Nebraska	$19.40	Nebraska	$21.50	Nebraska	$33.40
Nevada	$17.70	Nevada	n/a	Nevada	$36.20
New Hampshire	$25.10	New Hampshire	n/a	New Hampshire	$46.20
New Jersey	$27.80	New Jersey	$34.70	New Jersey	$49.50
New Mexico	$21.40	New Mexico	$27.60	New Mexico	$41.20
New York	$21.40	New York	$27.60	New York	$41.20
North Carolina	$33.10	North Carolina	$36.10	North Carolina	$51
North Dakota	$19.40	North Dakota	$21.50	North Dakota	$33.40
Ohio	$23.10	Ohio	n/a	Ohio	$43.50
Oklahoma	$30.50	Oklahoma	$37.60	Oklahoma	$52.80
Oregon	$24.30	Oregon	$30.80	Oregon	$45
Pennsylvania	$24.30	Pennsylvania	$30.80	Pennsylvania	$45
Rhode Island	$22.10	Rhode Island	n/a	Rhode Island	$42.20
South Carolina	$32	South Carolina	$34.90	South Carolina	$49.60
South Dakota	$19.40	South Dakota	$21.50	South Dakota	$33.40
Tennessee	$27.80	Tennessee	$34.70	Tennessee	$49.50
Texas	$27.80	Texas	$30.50	Texas	$44.50
Utah	$26.20	Utah	$32.90	Utah	$47.40
Vermont	$22.10	Vermont	n/a	Vermont	$42.20
Virginia	$27	Virginia	n/a	Virginia	$48.50
Washington	$24.30	Washington	$30.80	Washington	$45
Washington DC	$30.50	Washington DC	$37.60	Washington DC	$52.80
West Virginia	$24.30	West Virginia	$30.80	West Virginia	$45
Wisconsin	$26.20	Wisconsin	n/a	Wisconsin	$47.40
Wyoming	$19.40	Wyoming	$21.50	Wyoming	$33.40

Please note: The UniCare MedicareRx Rewards Plus plan is not available in the following states: California, Colorado, Connecticut, Georgia, Indiana, Kansas, Kentucky, Maine, Massachusetts, Missouri, New Hampshire, Nevada, Ohio, Rhode Island, Vermont, Virginia and Wisconsin.