

Seniors Choice Part D Prescription Drug Program Enrollment Form for Individuals

Medco Medicare Prescription Plan®(PDP)

Offered through the Merchants Industry Group Insurance Trust Fund

Enrollee Information: Requested effective date: ____/____/____

Member Name: _____
First MI Last

Street Address: _____

City, State, Zip: _____ Date of Birth: ____/____/____

Gender: Male Female Medicare (HIC): _____

Telephone #: (____) _____ - _____ Email Address: _____

Are you currently enrolled in a Creditable Part D Plan? Yes No

If "Yes", Plan Name: _____

Prescription Plan Election: Choice Preferred Premier

Payment Method: Direct Bill* PAC Credit Card
(Check one box to indicate method of payment) *First Modal Premium is due in the form of a check if using this payment method

Premium Mode: Monthly Quarterly Semi-annual Annual
(Check one box to indicate frequency of payment)

Pre-Authorized Check (PAC) Draft Authorization

As a convenience to me, I authorize MBA, Inc., administrator of Seniors Choice, to debit premiums and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below. I also authorize said Bank to debit and, if applicable, credit the amount of those entries to my account made payable to the order of MBA, Inc., Scottsdale, AZ by the due date of each month.

Bank Account Information

Bank/Financial Institution Name: _____ City: _____

Name on Bank Acct: _____ State: _____ Zip: _____

Checking Acct #: _____ Transit/Routing #: _____

I understand and agree that:

- | | |
|--|--|
| <ol style="list-style-type: none"> The Bank's right with respect to each charge will be the same as if personally executed by me; This authorization will remain in effect until I provide written notification to MBA, Inc. that I wish to revoke; MBA, Inc. and my Bank may discontinue this service; I further agree that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such debit, other than my monthly banking statement; | <ol style="list-style-type: none"> The presentation of such debit shall constitute due notice of premiums being due for a policy of insurance on my behalf. I understand that should my Bank dishonor any such debit or draft for any reason, it will be my responsibility to make arrangements with MBA, Inc. for premium payments within the grace period to prevent lapse or possible termination of the policy. It is also understood that MBA, Inc. assumes no responsibility for bank charges on these draws. |
|--|--|

Signature of Premium Payer: _____ Date: _____

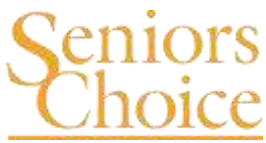
Credit Card Authorization

Name on Card: _____ Card Type: MC Visa Exp. Date: ____/____/____

Card Address: _____ Card #: _____

Member Signature: _____ Date: _____

Deduction Authorization: I hereby authorize the insurance premiums to be deducted monthly from my credit card and remitted to Seniors Choice. This authority is to remain in effect until I cancel it by written notification to MBA, Inc. at least 31 days in advance of the intended termination date of coverage. Any excess premium which may accrue after termination of my coverage will be refunded to me.



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Terms and Conditions of Enrollment:

To be eligible under the Merchants Industry Fund Group Insurance Trust, you must be covered under Medicare Part A only or Parts A & B.

On behalf of myself, I am requesting enrollment under the Seniors Choice Part D Prescription Drug Program offered through Merchants Industry Fund Group Insurance Trust. By signing this enrollment form, I agree to and understand the following:

- 1) **Prescription Coverage:** Is offered by Medco Containment Life Insurance Company. The Medicare Prescription Drug Coverage is administered by Medco Medicare Prescription Plan which is a creditable Part D Plan as governed by CMS.
- 2) By joining this Medco Medicare Prescription Plan, I acknowledge that Medco Medicare Prescription Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medco Medicare Prescription Plan will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- 3) **The Seniors Choice Part D Prescription Drug Program** 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 the Seniors Choice Part D Prescription Drug Program 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 a Seniors Choice Part D Prescription Drug Plan will end that enrollment. 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:
 - a) The Seniors Choice Part D Prescription Drug Plan or by calling 1-800-Medicare, 24 hours per day, 7 days per week.
 - b) TTY users should call 1-877-486-2048. Final approval of the effective date of enrollment is determined by CMS.
- 4) **Prescription Coverage:** I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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.
- 5) **Prescription Coverage:** Once I am a member of Medco Medicare Prescription Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medco Medicare Prescription Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
- 6) 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 dis-enrolled from the plan.
- 7) 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:
 - a) This person is authorized under State law to complete this enrollment and
 - b) Documentation of this authority is available upon request by the Seniors Choice Part D Prescription Drug Program or by Medicare.
- 8) 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.

Member Signature: _____ Date: _____

Agency Information:

Agent Name: _____ Agent Code: _____
Agent Email: _____ Agent Phone: _____

For more information, contact Seniors Choice at (800) 800-6543 or visit www.seniorschoiceplan.com

Administered By:



Prescription Coverage Underwritten by:
Medco Containment Life Insurance Company

MIFGIT