

Integration with Medicare

3. Are you covered by Medicaid?

Retiree Yes No **Dependent Spouse** Yes No

Check Desired Coverage: (Retiree and Spouse must be on the same plan.)

	Low Option Plan
Retiree (and Spouse if enrolling)	
Surviving Spouse	

Complete this form answering all questions. Please be sure to date and sign the form and return to:
EUCLID HEALTH TRUST
C/O NEBCO, 144 Metro Center Blvd., Suite 1, Warwick, RI 02886

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date: _____ Retiree Signature: _____

Date: _____ Dependent Spouse Signature: _____
(if enrolling)

2009 ENROLLMENT FORM (retiree & spouse)

THIS IS AN EMPLOYER GROUP MEDICARE PART D PRESCRIPTION DRUG PLAN

To enroll in the Sterling Retiree Rx Prescription Drug Plan, please provide the following information and **be sure to sign the back of the form.**

RETIREE

EFFECTIVE DATE:

Name					
Street Address					
City		State		Zip Code	
Date of Birth		Social Security Number (optional)			
Gender		Medicare ID # (from Medicare ID Card)			
Phone Number		E-Mail Address			

SPOUSE

Name					
Street Address					
City		State		Zip Code	
Date of Birth		Social Security Number (optional)			
Gender		Medicare ID # (from Medicare ID Card)			
Phone Number		E-Mail Address			

ALTERNATIVE CONTACT

Name			
Phone Number		Relationship to You:	

SELECT YOUR ENROLLMENT OPTIONS BELOW (Please Check Desired Coverage)

PRESCRIPTION DRUGS: Please select the Rx plan below for yourself and your spouse, if enrolling.



- Retiree: Sterling Retiree Rx Base Plan Spouse: Sterling Retiree Rx Base Plan
 Retiree: Enhanced Rx Plan (ENH 01) Spouse: Enhanced Rx Plan (ENH 01)

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(s) 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.

 <p>MEDICARE HEALTH INSURANCE</p> <p>FOR RETIREE (SAMPLE ONLY)</p> <p>Name: _____</p> <p>Medicare Claim Number: _____ Sex: _____</p> <table border="1"> <thead> <tr> <th>Is Entitled To</th> <th>Effective Date</th> </tr> </thead> <tbody> <tr> <td>HOSPITAL (Part A)</td> <td>_____</td> </tr> <tr> <td>MEDICAL (Part B)</td> <td>_____</td> </tr> </tbody> </table>	Is Entitled To	Effective Date	HOSPITAL (Part A)	_____	MEDICAL (Part B)	_____	 <p>MEDICARE HEALTH INSURANCE</p> <p>FOR SPOUSE – if enrolling (SAMPLE ONLY)</p> <p>Name: _____</p> <p>Medicare Claim Number: _____ Sex: _____</p> <table border="1"> <thead> <tr> <th>Is Entitled To</th> <th>Effective Date</th> </tr> </thead> <tbody> <tr> <td>HOSPITAL (Part A)</td> <td>_____</td> </tr> <tr> <td>MEDICAL (Part B)</td> <td>_____</td> </tr> </tbody> </table>	Is Entitled To	Effective Date	HOSPITAL (Part A)	_____	MEDICAL (Part B)	_____
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Paying Your Plan Premium:

You can pay your monthly plan premium by mail or Electronic Funds Transfer each month.

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 does not cover. *If you don't select a payment option, you will receive a bill each month. Please select a premium payment option:*

Premium Payment Options:

Receive a bill monthly _____

Electronic Funds Transfer _____ Please see instructions below:

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

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: Checking _____ Saving _____

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 Sterling Retiree Rx?

Yes No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

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 (number and street) & Phone Number of Institution: _____

Please Read This Important Information:

If you are a member of 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 Sterling Retiree Rx, 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 have questions, contact your Medicare Advantage plan.

If you currently have health coverage from another employer or union, i.e., through your spouse or another former employer, joining Sterling Retiree Rx could affect your employer or union health benefits. If you have health coverage from another employer or union, and you enroll in Sterling Retiree Rx, we may coordinate the benefits between your other plan and Sterling Retiree Rx. 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 can help.

Please Read This Important Information and Sign Below:

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

Sterling Retiree Rx (PDP) 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 Sterling Retiree Rx 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 the PDP 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 Sterling Retiree Rx or by calling 1-800-Medicare, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

Sterling Retiree Rx is a national employer group so if I move out of state, I can remain enrolled in the plan. I will notify the Plan of my address change. Once I am a member of Sterling Retiree Rx, I have the right to appeal plan decisions about payment or services with which I disagree. I will read the Evidence of Coverage document from Sterling Retiree Rx 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 Sterling Retiree Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Sterling Retiree Rx 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. 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 the laws of the State where I reside) 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 Sterling Retiree Rx or by Medicare.

Retiree's Signature:	Today's Date:
Spouse's Signature:	Today's Date:

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

Name:

Address:

Phone Number:

Relationship to Enrollee:

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative Signature: _____