

Section 3: Paying Your Plan Premium

You can pay your Medicare prescription drug plan monthly premium by mail, by Automatic Bank Draft Withdrawal, or by automatic deduction from your Social Security check.

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.

How would you like to pay your monthly Medicare prescription drug plan premium? Please check the appropriate box:

- Automatic Bank Draft Withdrawal. Please send us a VOIDED check and fill in the requested information, which allows us to deduct your monthly payment from your bank account. Please choose one of the following:

By selecting Automatic Bank Withdrawal, I authorize the bank or financial organization named below to pay my premium through electronic bank withdrawal payable to American Progressive Life & Health Insurance Company of New York or Pennsylvania Life Insurance Company. The bank or other financial organization will be fully protected in honoring these payments until written notice from me canceling this request is received.

Please choose one of the following: Checking Savings

Name on Account: _____

Financial Institution: _____

Routing Number: _____

Account Number: _____

Name _____	2008
Address _____	Date _____
City, State Zip _____	Pay to the order of _____ \$ _____ Dollars
Memo _____	_____ 2008

Routing Number Account Number

Account Holder Signature _____

- Monthly payments by personal check. You will be mailed a premium statement each month.
Do not send payment with this enrollment form.
- Social Security check deduction. Please note: Social Security Administration (SSA) deduction is completed through the SSA and may take two or more months to process. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Section 4: Please Read and Answer These Important Questions

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 PrescribaRx plan? Yes No

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

Name of 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: _____ Phone Number: _____ - _____ - _____

Address of Institution (number and street): _____

City: _____ State: _____ ZIP Code: _____

3. Please check this box if you would prefer information in Spanish.
Please contact PrescribaRx at 1-800-818-0007, TTY 1-800-958-2692, if you need information in another format or language. Our hours of operation are 8AM to 8PM - 7 days a week.

Section 5: Information to Determine Enrollment Periods

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. The Enrollment Department may contact you if additional information is needed. If we later determine that this information is incorrect, you may be disenrolled.

- I am enrolling during the Annual Enrollment Period (November 15th — December 31st)
- I am new to Medicare.
- I recently moved outside of my current service area for Medicare health plan or Medicare prescription drug plan.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I was recently approved to receive extra help paying for Medicare prescription drug coverage.
- I just moved into or out of a skilled nursing facility (such as a nursing home, psychiatric hospital, etc.)
- I recently left a PACE program.
- I recently and involuntarily lost my coverage that is at least as good as Medicare's (also referred to as "creditable coverage").
- I am either losing coverage I had from an employer or leaving employer coverage.
- Other (Please explain) _____
- None of these statements applies to me. *Please contact PrescribaRx at 1-800-818-0007 (TTY users should call 1-800-958-2692) to see if you are eligible to enroll. Our hours of operation are 8AM to 8PM - 7 days a week.

STOP

Section 6: Please Read This Important Information

STOP

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 PrescribaRx, 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 an employer or union, joining PrescribaRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining PrescribaRx 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 can help.

Section 7: Please Read and Sign on Page 4

By completing this enrollment application, I agree to the following: PrescribaRx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform PrescribaRx 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 PrescribaRx 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 (November 15 – December 31) – unless I qualify for certain special circumstances.

PrescribaRx serves a specific service area. If I move out of the area that PrescribaRx 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 to access PrescribaRx benefits, except under limited, non-routine circumstances when I cannot reasonably use PrescribaRx network pharmacies. Once I am a member of PrescribaRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PrescribaRx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

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.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with PrescribaRx, he/she may be compensated based on my enrollment in PrescribaRx. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage

