OKLAHOMA
Employees Group
Insurance Division

Who can use this form? People with Medicare who want to join a Medicare prescription drug plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

Important:
To join a HealthChoice SilverScript Medicare supplement with prescription drug plan, you must have either or both:

- Medicare Part A (hospital insurance).
- Medicare Part B (medical insurance).

To join the BCBSOK Medicare supplement with prescription drug plan, you must have both:

- Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).

When do I use this form?
You can join a plan:

- Between Oct. 15-Dec. 7 each year (for coverage starting Jan. 1).
- Within three months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans. Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card).
- Your permanent address and phone number.

Reminder:

- If you want to join a plan during fall open enrollment (Oct. 15-Dec. 7), the plan must have your completed form by Dec. 7.

What happens next?
Send your completed and signed form to:
OHCA EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Once they process your request to join, they'll contact you.

How do I get help with this form?
Call EGID Member Services at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711. Or, call Medicare at 800-MEDICARE (800-633-4227). TTY users call 877-486-2048. **En español:** Llame a EGID al 800-752-9475/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estara disponible para asistirle.

Individuals experiencing homelessness
If you want to join a plan but have no permanent residence, a post office box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

OKLAHOMA
Employees Group
Insurance Division

APPLICATION FOR MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLAN

Member information

Member name (First	MI	Last)	Member ID

Date of birth	☐ Male ☐ Female	Member SSN

Permanent address (P.O. Box not allowed)	City	State	ZIP code

Mailing address (if different from above)	City	State	ZIP code

Phone	Alternate phone	Email

Dependent information (only if enrolling in Medicare)

Dependent name (First	MI	Last)

Date of birth	☐ Male ☐ Female	Dependent SSN

Your Medicare information (required to process your application)

Name on Medicare card:

Medicare number: __ __ __ __ - __ __ __ - __ __ __ __

Part A effective date:

Part B effective date:

To participate in the BCBSOK Medicare supplement plan, you must be enrolled in both Medicare Part A (hospital) and Part B (medical) and continue to pay your monthly Part B premium. To participate in the HealthChoice Medicare supplement plans, you must be entitled to benefits under Medicare Part A. You are not required to enroll in Part B, but the plan pays benefits as if you are enrolled. To maximize your benefits, you need to be enrolled in Medicare Part B.

Answer these important questions

1. In which Medicare supplement with Medicare Part D prescription drug plan do you want to enroll?

HealthChoice SilverScript Medicare Supplement Plan
☐ High ☐ Low

☐ BCBSOK – BlueSecure

2. Do you have End State Renal Disease (ESRD)? ☐ Yes ☐ No

3. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through the Oklahoma Health Care Authority Employees Group Insurance Division?

☐ Yes
☐ No

Name of other coverage	ID#	Group#

4. Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period. (Refer to statements below.)

☐ I am enrolling during an Annual Enrollment Period (Option Period).

Read the following statements 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. If we later determine that this information is incorrect, you may be disenrolled.

☐	I am new to Medicare.
☐	I recently moved outside of the service area of my current plan. I moved on (insert date):
☐	I recently was released from incarceration. I was released on (insert date):
☐	I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date):
☐	I recently obtained lawful presence status in the U.S. I got this status on (insert date):
☐	I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date):
☐	I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help or lost Extra Help) on (insert date):
☐	I live in or recently moved out of a long-term care facility (for example, a nursing home or other long-term care facility). I moved/will move into/out of the facility on (insert date):
☐	I recently left a PACE program on (insert date):
☐	I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date):
☐	I am leaving employer or union coverage on (insert date):
☐	I belong to a pharmacy assistance program provided by my state or am losing help from a pharmacy assistance program provided by my state.
☐	I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date):
☐	I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
☐	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐	None of these statements apply to me. Call EGID at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711.

It is your choice to answer these questions. You cannot be denied coverage if you don't answer.

5. Select if you want to receive plan information in a language other than English.

☐ Spanish ☐ No other language requested

6. Select one if you want to receive plan information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ No accessible format requested

Signatures – Important: Read and sign below

- I must keep Part A or Part B to stay in the plans offered by EGID.
- By joining this Medicare supplement with prescription drug plan, I acknowledge that the Medicare supplement with prescription drug plans offered by EGID will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to federal statutes that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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 legally authorized to act on my behalf) on this application means I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment.
    2) Documentation of this authority is available upon request by Medicare.

Member signature	Date
Dependent signature (only if dependent is enrolling in Medicare)	Date

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

Name	Phone
Address	Relationship to enrollee

For individuals helping enrollee complete this form*

*Complete this section if you are an agent, broker, SHIP counselor, family member or other third party.

Name	Relationship to enrollee
Signature	National Producer Number (agent/broker only)

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

2026 monthly premium information – does not reflect any retirement system contribution

MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLANS	
BCBSOK – BlueSecure	$568.78 per covered person
HealthChoice SilverScript High Option Medicare Supplement	$437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$356.06 per covered person

Mail, email or fax the form to Attn: Member Accounts

Mail: OHCA EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Email: egidmail@ohca.ok.gov

Fax: 405-717-8939

If you have questions, call EGID Member Services at 405-717-8780 or toll-free 800-752-9475. TTY users call 711.