## Network Pharmacies Near You

### Do You Have Questions Or Want To Enroll With A TEAMStar® Customer Service Representative Over The Phone?

**Call: 1-877-577-3880**
8 a.m. - 8 p.m.
(in your local time zone).

Do you use a hearing impaired TTY/TDD phone?
**Call: 711**

It's easy to find information and apply online too. Log on today at http://www.teamstarpartd.com!

INTERNATIONAL BROTHERHOOD OF TEAMSTERS
25 LOUISIANA AVENUE, N.W. • WASHINGTON, D.C. 20001

### AN IMPORTANT MESSAGE FROM THE GENERAL PRESIDENT

Dear Fellow Teamster,

The International Brotherhood of Teamsters is once again proud to offer the TEAM*Star*® Medicare Part D Prescription Drug Program (PDP) to Medicare-eligible Teamster retirees! This program is designed to help you reduce your current prescription drug costs and insure you against high prescription drug expenses in the future. Every year we strive to develop an affordable prescription drug plan to enable our Teamster members to save as much money as possible. Please review the enclosed materials for details on our TEAM*Star*® 2021 coverage, rates and enrollment.

Fraternally,

James P. Hoffa
General President

Ken Hall
General Secretary - Treasurer

FPO BUG

TEAM*Star*® Part D is a PDP with a Medicare contract.
Enrollment in TEAM*Star*® Part D depends on contract renewal.



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## TEAMSTAR® MEDICARE PART D PRESCRIPTION DRUG PROGRAM (PDP) ENROLLMENT FORM

ADMINISTERED BY UNITED AMERICAN INSURANCE COMPANY, McKINNEY, TEXAS

### PLEASE SELECT PLAN

- ○ **Bronze** Plan — Monthly Direct Bill: $56.10; Monthly Bank Draft: $55.10
- ○ **Silver** Plan — Monthly Direct Bill: $115.40; Monthly Bank Draft: $114.40
- ○ **Platinum** Plan — Monthly Direct Bill: $198.60; Monthly Bank Draft: $197.60

### PLEASE PROVIDE INFORMATION ABOUT YOU. PLEASE PRINT CLEARLY

Email Address

☐ Mr. ☐ Mrs. ☐ Ms.

Home Phone Number
(     )

SEX ☐ M ☐ F

Birth Date
______ (MM) ______ (DD) ______ (YYYY)

Mailing Address: Street Address (only if different from your Permanent Residence Address)

City : ____________ State: ____________ Zip: ________

### PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

**Please take out your red, white and blue Medicare card to complete this section.**

- Fill out this information as it appears on your Medicare card

— OR —

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): ____________

Medicare Number: ____________

Is Entitled To: Effective Date:
**HOSPITAL (Part A)** ____________
**MEDICAL (Part B)** ____________

You must have Medicare Part A and Part B to join a Medicare Part D Prescription Drug Plan (PDP).

### ANSWER THESE IMPORTANT QUESTIONS:

**Will you have other prescription drug coverage (like VA, TRICARE) in addition to TEAMStar Medicare Part D?** ○ YES ○ NO

Name of other coverage: ________ Member number for this coverage: ________ Group number for this coverage ________

## IMPORTANT: PLEASE READ AND SIGN ON REVERSE SIDE

- I must keep Hospital (Part A) or Medical (Part B) to stay in TEAMStar Medicare Part D Prescription Drug Program.
- By joining this Medicare Prescription Drug Plan, I acknowledge that TEAMStar Medicare Part D Prescription Drug Program will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- My response to this form is voluntary. However, failure to respond may affect enrollment in the 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that 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, and
  2) Documentation of this authority is available upon request by Medicare.

ENROLLMENT FORM CONTINUED ON REVERSE SIDE

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## IMPORTANT: PLEASE SIGN BELOW

| SIGNATURE: | Today's Date: | Affiliated with IBT Local #: |
|---|---|---|
| | | |

**IF YOU ARE THE AUTHORIZED REPRESENTATIVE, YOU MUST SIGN ABOVE AND PROVIDE THE FOLLOWING INFORMATION:**

Name : ______________________________

Address : ______________________________

Phone Number: (_______)__________-____________ Relationship to Enrollee: ______________________

### SECTION 2 - ALL FIELDS ON THIS PAGE ARE OPTIONAL

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in an accessible format.

- ❑ Braille
- ❑ Large print
- ❑ Please contact TEAMStar Medicare Part D Prescription Drug Program at 1-866-524-4173 if you need information in an accessible format other than what's listed here. Our office hours are Monday - Friday 8am to 8pm EST. TTY users can call 711.

### Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may by mail or Electronic Funds Transfer (EFT) each month, quarterly, semi-annually or annually. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay TEAMStar Medicare Part D the Part DIRMAA.

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

- ○ I would like my Medicare prescription drug plan premiums deducted monthly from my checking account (Monthly Bank Draft). (Please complete authorization on the next page.)
- ○ I want to be billed monthly (Direct Bill).

**If you wish to pay by Automatic Bank Draft and save an additional $1.00 per payment, please complete the form below.**

**"AUTOMATIC" PAYMENT PLAN AUTHORIZATION**

Please tape a personalized voided check. DO NOT STAPLE.

**AUTOMATIC PAYMENT PLAN AUTHORIZATION:** I authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United American Insurance Company. This authorization is to remain in effect until revoked by me in writing. All premiums/fees may be automatically withdrawn from my account on a MONTHLY basis.

Name
Address
City, State Zip
117
Pay to the order of: $ Dollars
VOID
Memo:
⑆ 123456789 ⑆ 12 34567890 117

Bank Routing Number Bank Account Number

**NOTE:** If Draft Day selected is the 18th or greater, your Part D premium will draft in the month prior to your due date.

**Bank Draft Day** [ | ] *Day of the month you want your account to be drafted – 01 to 28 only.*

______________________________
Account Holder's Signature (as it appears on financial institution records)

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 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.

## INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

**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 Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

**When do I use this form?**

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 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

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

**Reminders:**

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

**What happens next?**

Send your completed and signed form to:
TEAMStar Medicare Part D Prescription Drug Program (PDP)
P.O. Box 8080
McKinney, TX 75070

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

**How do I get help with this form?**

Call TEAMStar Medicare Part D Prescription Drug Program at 1-866-524-4173. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a TEAMStar Medicare Part D Prescription Drug Program al 1-866-524-4173 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Accordng to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**IMPORTANT**

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

### TEAM*Star*® Advantages

- **Nationwide Availability** – available in all 50 states, the District of Columbia and all U.S. territories
- **Comprehensive Drug Coverage And Pharmacy Network** – approximately 3,600 prescription drugs available at over 64,000 pharmacies nationwide
- **Union Pricing** – Low Cost Generic drugs are available during the Initial Coverage Period at only $5 for a one-month supply when filled at a Union-Designated pharmacy.
- **Coverage Options** – three unique plans that offer different levels of security to Teamsters
- **Competitive Union Group Rates** – TEAM*Star*® Medicare Part D is not available to the general public. The rates and benefits are set by your union.
- **Generic Coverage Through The Donut Hole** – if you select the Platinum Plan you can get coverage for most generics at a low copay after you get to the Coverage Gap.
- **Priority One Enrollment** – because you are a Teamster, a spouse or a surviving spouse of a Teamster, you will receive immediate priority in processing your enrollment. We have reserved a spot for you in the program.

See Other Side For An Important Message From The General President...