

**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 January 1)
- 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.

According 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.

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.

2054395053

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: \$61.60 | Monthly Bank Draft: \$60.60 | **Silver Plan** Monthly Direct Bill: \$125.50 | Monthly Bank Draft: \$124.50 | **Platinum Plan** Monthly Direct Bill: \$216.00 | Monthly Bank Draft: \$215.00

PLEASE PROVIDE INFORMATION ABOUT YOU. PLEASE PRINT CLEARLY

	Email Address
	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
	Home Phone Number ()
	SEX <input type="checkbox"/> M <input type="checkbox"/> 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

**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!>



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 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 in your local time zone. TTY users can call 711.
- Large print

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe 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 D-IRMAA.

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
Memo:	
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 0 1 1 7
Bank Routing Number	Bank Account Number

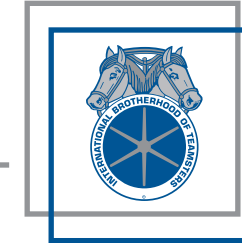
VOID

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.

**INTERNATIONAL
BROTHERHOOD OF TEAMSTERS**

25 LOUISIANA AVENUE, N.W. • WASHINGTON, D.C. 20001



Dear Brother or Sister:

Navigating through Medicare Part D offers can be overwhelming, so it's smart to start by narrowing the choices to the ones you know and can trust. The TEAMStar® Medicare Part D Prescription Drug Program is the only exclusive Part D program developed for you by your union with your best interests at heart.

If you are turning 65, you can enroll in TEAMStar® Medicare Part D during 90 days prior to and after your 65th birthday. Don't wait - this time is limited. If you are not turning 65, you may still qualify for a special enrollment period. Call us for more details using the phone number in the box below.

The IBT offers three Medicare Part D plans to allow choices. Each plan offers something a little different regarding the coverage they provide. No matter which TEAMStar® Part D plan you choose, you pay the same low copay for Tier 1 and Tier 2 drugs in the Initial Coverage Period. For all TEAMStar® Part D plans, you will only have to pay \$5 for Tier 1 prescriptions when you have your 30-day prescription filled at a Union-Designated pharmacy.

Whether you are purchasing Part D prescription drug coverage for the first time, or you are looking for a better alternative, please consider this union program carefully. If you currently have prescription drug coverage through your former employer or welfare fund, please discuss this union program with your benefits administrator before enrolling in TEAMStar® Medicare Part D to make sure enrollment won't negatively impact your existing coverage.

Enrolling is easy. Everything you need to make a decision about this program is included in this package.

Sincerely,

John Slatery, Executive Director
International Brotherhood of Teamsters Voluntary Employee Benefits Trust

P.S. Attached to your application, we've included just a few retail pharmacies from our network near your home. We offer nationwide coverage with over 64,000 participating pharmacies.

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 www.teamstarpard.com!

TEAMStar® Part D is a PDP with a Medicare contract. Enrollment in TEAMStar® Part D depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan.

TEAMStar® Advantages

- **Nationwide Availability** – available in all 50 states, the District of Columbia and all U.S. territories.
- **Comprehensive Drug Coverage And Pharmacy Network** – approximately 5,500 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** – TEAMStar® 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.

