STANDARD ENROLLMENT FORM FOR A MEDICARE-APPROVED DRUG DISCOUNT CARD

Drug Card Sponsor Name	Drug Card Product Name
Enrollment Fee	Drug Card Sponsor Address

STEP 1: PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you have Medicare Part A or Medicare Part B? ❑ Yes ❑ No

If you answered "YES," please continue below. If you answered "NO," you are not eligible to enroll in a Medicare-approved drug discount card.

Do you have outpatient prescription drug benefits under your State Medicaid Program? ❑ Yes ❑ No

If you answered "NO," please continue below. If you answered "YES," you are not eligible to enroll in a Medicare-approved drug discount card.

STEP 2: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF

First Name	Middle Initial	Last Name	Date of Birth *(month/day/year)*	Sex

Residence Address: Street	City	State	ZIP Code

Social Security Number	Medicare ID Number *(from your red, white & blue Medicare card)*	Telephone Number *(with area code)*

PLEASE CONTINUE TO THE NEXT PAGE

Step 3: Read all the information

Release of Information: By applying for enrollment for a Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company that sponsors the drug discount card. The information will say whether I have Medicare (Hospital Insurance Part A and/or Medical Insurance Part B). I also allow the State Medicaid Program or any other agency with relevant information about me to give CMS or CMS' agents the information needed to determine if I am eligible for drug discount card.

Review of Eligibility: I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that by signing this application I am agreeing to a full investigation or review of my eligibility by States, Federal agencies, or their contractors and, if requested, I agree to provide the documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents aren't available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, you certify that you have read and understand the information on this enrollment form. If you can't sign, a representative may sign for you. Federal law provides for fine or imprisonment, or both for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature_____Date_____

You must return this completed enrollment form to the Medicare-approved drug discount card sponsor you have selected. Do not return your form to CMS. If you don't send this completed form to the sponsor you have chosen, your enrollment will be delayed.

NOTE: Medicare provides a $600 credit for some people with low income. If you would like to apply for the Medicare-approved drug discount card **AND** a credit of up to $600 to help pay for your prescription drugs, please fill out and return Form CMS-20016-B, **Standard Enrollment Form For A Medicare-Approved Drug Discount Card and a Credit to Help Pay For Your Prescription Drugs** instead of this one.