



Express Scripts Medicare (PDP) Enrollment Form

Employer: Electric Boat Corporation – LIMITED Rx Plan

Effective date of coverage _____

Personal Applicant Information – As it appears on your Medicare card			
If both retiree and spouse are enrolling, each applicant will need their own form			
Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Social Security #	
Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date	
Are you the Retiree? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If the answer is no, what is your relationship to the retiree? <input type="checkbox"/> Spouse <input type="checkbox"/> Surviving Spouse			
Name of Retiree _____			
Retiree Social Security # _____ Retiree Date of Birth _____			
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If “no”, please provide your retirement date _____			
If “yes”, are you working full-time or part-time _____			
Mailing Address		City	
		State	Zip Code
Legal Street Address (if different than above)		City	
		State	Zip Code
Home Telephone ()	Alternative Phone (Cell) ()	County	
Email Address			
Do we have your permission to email you? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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 the Express Scripts Medicare (PDP) plan? ___ Yes ___ No

If "yes" please list your other coverage and you identification (ID) numbers for this coverage:

Name of other coverage	ID# for this coverage	Group# for this coverage
_____	_____	_____

By signing below, I agree that I have read and understand that I will be enrolling into the Electric Boat Prescription Drug Plan administered by Express Scripts Medicare (PDP).

This enrollment form must be signed, dated and received prior to your desired effective date. Upon receipt, your form will be processed and your enrollment will be sent to Express Scripts Medicare. The plan will submit your enrollment to CMS in accordance with CMS (Centers for Medicare and Medicaid) guidelines.

Applicant Signature (or signature of authorized representative)	Date signed
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If you are the authorized representative of the applicant, you must provide the following information and sign below. If signed by an authorized representative of the applicant, 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 Beacon Retiree Benefits Group, Express Scripts Medicare or Medicare.

Name (Print)	Signature
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Address

Telephone Number	Relationship to Applicant
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If someone assisted you in completing this form, please have that person complete the information below:

Signature of Individual Who Assisted in Completing this Form	Relationship to Applicant
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Date: _____