2026 SilverScript® Insurance Company

SilverScript Employer PDP sponsored by PSC-CUNY Welfare Fund (SilverScript)
Medicare Part D Enrollment Form

Section 1: Please Read This Important Information

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment Period. Please read the following statements carefully 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 that reason which will help us determine your enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

Reasons for Annual Enrollment Period Eligibility

☐ I am enrolling during the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I am new to Medicare. ☐ I have previously had Medicare but am now turning 65.

Reasons for Special Enrollment Period Eligibility (Select reason and enter date if applicable)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on _ _/_ _ /_ _ _ _.

☐ I recently was released from incarceration. I was released on _ _/_ _ /_ _ _ _.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _ _/_ _ /_ _ _ _.

☐ I recently obtained lawful presence status in the United States. I got this status on _ _/_ _ /_ _ _ _.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _ _/_ _ /_ _ _ _.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on _ _/_ _ /_ _ _ _.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on _ _/_ _ /_ _ _ _.

☐ I recently left a PACE program on _ _/_ _ /_ _ _ _.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on _ _/_ _ /_ _ _ _.

☐ I am leaving employer or union coverage on _ _/_ _ /_ _ _ _.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ 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 _ _/_ _ /_ _ _ _.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ None of these statements apply to me. Please contact SilverScript Insurance Company at 1-866-881-8573, 24 hours a day, 7 days a week (TTY users call 711).

Section 2: To Enroll in SilverScript Provide the Following Information	
Please check the SilverScript plan in which you wish to enroll. ☐ SilverScript	**Today's Date** __/__/____ **Requested Coverage Effective Date** __/__/____

Section 3: Complete the Information Below Exactly as it Appears on Your Medicare Card

Use your Medicare card to complete this section.
Please fill in these blanks so they match your red, white and blue Medicare card.
– OR –
Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.
You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.
Last Name _____ Suffix ____
First Name _____ MI __
Medicare Number _____

Is Entitled to	Effective Date
Hospital Insurance (Part A)	__ __ / __ __ /__ __ __ __
Medical Insurance (Part B)	__ __ / __ __ /__ __ __ __

Please Provide the Following Information

Birth Date __/__/____ M M / D D / Y Y Y Y	**Sex** ☐ M ☐ F	**Primary Phone Number** (___) ___–____ **Cell Phone Number** (___) ___–____

Permanent Residence / Long-term Care Facility Address (PO Box is not allowed)
Street Number Street Name
_____ _____

Apt/Suite/Unit _____	**City** _____	
County _____	**State** __	**ZIP Code** _____-_____

Long-term Care Facility Name _____

Mailing Street Address
Street Number Street Name
_____ _____

Apt/Suite/Unit _____	**City** _____	
County _____	**State** __	**ZIP Code** _____-_____

E-mail Address (optional) _____

Section 4: Paying Your Plan Premium

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount. You will be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to SilverScript Insurance Company.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, deductibles and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty.

Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Section 5: Please Read and Answer These Important Questions

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 SilverScript Employer PDP?

☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

The shaded line shows how this may appear on your card.

Plan Name	Effective Date	Term Date	RxBin	RxPCN	RxGroup	RxID#
ABC Insurance	10/01/2009	12/31/2018	123456	0049876912	ABC1234	123456789

¿Le gustaría recibir esta información en español? ☐ ¿Sí? ☐ No

If you need information in an alternate language or accessible format, such as braille, audio tape or large print, please contact SilverScript Customer Care at 1-866-881-8573, 24 hours a day, 7 days a week (TTY users call 711).

STOP! Section 6: Please Read This Important Information STOP!

If you are a member of a Medicare Advantage Plan (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining SilverScript Employer PDP, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from another employer or union, joining SilverScript Employer PDP could affect your other employer or union health benefits. You could lose your employer or union health coverage if you join SilverScript Employer PDP. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 7: Please Read Terms and Sign in the "Applicant's Signature" section below

By completing this enrollment form, I agree to the following:

SilverScript Employer PDP is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform SilverScript of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in SilverScript will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period, unless I qualify for certain special circumstances.

SilverScript serves a specific service area. If I move out of the area that SilverScript serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use SilverScript network pharmacies. Once I am a member of SilverScript, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from SilverScript when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with SilverScript, he or she may be paid based on my enrollment in SilverScript.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information

By joining this Medicare Prescription Drug Plan, I acknowledge that SilverScript will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that SilverScript will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. 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 authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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.

Applicant's Signature	
Your Signature	**Today's Date**
Print Name *(please print)* ______________________________________	

Section 8: Power of Attorney / Authorized Representative
If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use) **Name** ______________________________________ **Address** ______________________________________ **City** ________________________ **State** ___ **ZIP Code** ______ **Phone Number** ___ — ____ — _____ **Relationship to Enrollee** ☐ Child ☐ Friend ☐ Spouse ☐ Other ___________ **Signature** ______________________ **Today's Date** __ / __ / ____ ☐ Please check if authorized representative should receive duplicate copy of plan materials.

STOP! Agent/Prescription Drug Plan Use Only – Please Complete STOP!
Application Received Date __ / __ / ____ ☐ IEP ☐ AEP ☐ SEP (type) ______________

When you've completed your Enrollment Form, sign, date and return it to your Employer Group Administrator.