Harvard Pilgrim Medicare Enhance, Health New England MedPlus, Tufts Medicare Complement and UniCare State Indemnity Plan/Medicare Extension (OME) Medicare Part D Opt-In Form

If you enroll in one of these GIC Medicare Plans, you will automatically be enrolled in SilverScript Employer PDP sponsored by the Group Insurance Commission (SilverScript) for your prescription drug coverage. SilverScript combines a standard Medicare Part D plan with additional coverage provided by the GIC. You must complete the information below after you have read the SilverScript Summary of Benefits. Your signature below certifies that you have read this document.

Please **read and check the box** if you choose the GIC-sponsored SilverScript prescription drug plan. **Provide any additional information needed** below and **sign the form** before returning to the GIC.

☐ I choose to receive prescription drug benefits from the GIC through SilverScript, along with my enrollment in Harvard Pilgrim Medicare Enhance, Health New England MedPlus, Tufts Medicare Complement or UniCare State Indemnity Plan/Medicare Extension (OME) plan for medical coverage. The GIC will automatically enroll me in Medicare Part D prescription drug coverage. I understand that I must enroll in Medicare Part A and/or Medicare Part B in order to be enrolled in Medicare Part D. The prescription drug premium is included in the monthly GIC health insurance premium payment.

I understand that if I am later dis-enrolled from the plan due to failure to pay Part B or because I enroll in a non-GIC Medicare Part D plan, I will lose both my GIC medical and prescription drug coverage. If I am the retiree, I also understand that my covered spouse/dependent(s) will also lose their GIC medical and prescription drug coverage.

By agreeing to be enrolled in a GIC Medicare Part D plan, I acknowledge that SilverScript will release my information to Medicare as is necessary for treatment, payment and health care operations. I also acknowledge that the plan will release my information, including my prescription drug data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. My personal health information will be protected as required by federal and state laws.

The information provided on this form is correct to the best of my knowledge. I understand that I may be dis-enrolled from the plan if I intentionally provide false information as part of my enrollment.

Medicare does not accept P.O. Boxes as an address. Please provide your street address below.

Name of Medicare-eligible Retiree or Spouse/Dependent _____ GIC ID of insured member (usually Soc. Sec#) _____

Street Address _____

City _____ State _____ ZIP Code _____

Signature of Retiree or Spouse/ Dependent who is Medicare eligible _____ Date _____

_____ Please check here if the person signing this form is the authorized representative for the Retiree or Spouse/Dependent.

Name of Authorized Representative (first/last – please print) _____ Phone Number _____

Address _____ City _____ State _____ ZIP Code _____

Power of Attorney: Note that a copy of Power of Attorney documents must be included.

You must also complete Retiree/Survivor Enrollment/Change Form (Form-RS)