EXPRESS SCRIPTS®
Medicare (PDP)

Express Scripts Medicare (PDP) Enrollment Form

Employer: Electric Boat Corporation – Limited 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 ☐ **Male** ☐ **Female**	**Marital Status** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**		**Social Security #**
Medicare Number	**Medicare Part A Effective Date**		**Medicare Part B Effective Date**
Are you the Retiree? Yes ☐ No ☐ **If the answer is no, what is your relationship to the retiree?** ☐ **Spouse** ☐ **Surviving Spouse** **Name of Retiree _____** **Retiree Social Security # _____ Retiree Date of Birth _____**			
Are you currently employed? ☐ **Yes** ☐ **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? ☐ **Yes** ☐ **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**

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**

_____

Address

_____

Telephone Number **Relationship to Applicant**

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**

Date: _____