BlueCross BlueShield
Federal Employee Program

FEP Medicare Prescription Drug Program Voluntary Enrollment Form

This form is for individuals who are not automatically enrolled in the FEP Medicare Prescription Drug Program (MPDP) but want to enroll and meet the eligibility requirements.

Eligibility Requirements

As a Blue Cross and Blue Shield Service Benefit Plan member, you can enroll in MPDP if you:

- Are a permanent resident of the U.S. or a U.S. territory.
- Have Medicare A and/or B primary.

There is no restriction on when you can enroll if you meet these requirements.

Instructions

Please read these instructions carefully before you fill out the form on the next page.

To complete the form, you will need the following items:

1. Your Medicare member ID card
2. Your FEP member ID card
3. Your unique MPDP number – call the customer service number on your current member ID card to receive this number.

Once you have the information above, fill out the form completely. Then you send it to:

FEP Medicare Prescription Drug Program
P.O. Box 3539
Scranton, PA 18505

Important: If there are multiple people in your household eligible for MPDP, you will each need to send in your own form.

Questions

If you have any questions about this form, please call **1-888-338-7737** (TTY: 711).

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Name and Contact Information		
First Name:	Last Name:	Middle Initial:
Birth Date:	Sex: Male ☐ Female ☐ Prefer Not to Say ☐	
Permanent U.S. Address (cannot be a PO box)		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Email (Optional):	
Mailing Address (if different than permanent address above)		
Street Address:		
City:	State:	Zip Code:
Health Plan Information		
Medicare Member ID: *Get this number from your Medicare ID card.*		
FEP Plan Name: FEP Blue Focus *Get this from your FEP member ID card.*	PBP ID: 803	
FEP Member ID: R *Get this from your FEP member ID card.*	MPDP Member ID: *Call the customer service number on your FEP member ID card for this number.*	

Acknowledgement

I understand that by enrolling in the FEP Medicare Prescription Drug Program (MPDP) I must keep my Medicare Part A and/or B coverage. I also know that this means that the Service Benefit Plan will share my information with Medicare who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.

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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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.

Signature:	Today's Date:
Authorized Representative (if applicable, sign above and fill in the fields below)	
Name:	Phone Number:
Address:	Relationship to Member:

Section 2 – All fields in this section are optional We will not deny your coverage if you choose not to answer these questions
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other
☐ Prefer Not to Answer
What is your race? Select all that apply.
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian and Pacific Islander
☐ White
☐ Other
☐ Prefer Not to Answer
Requests for material in a different format
☐ Check this box if you would like materials sent to you in Spanish ☐ Check this box if you would like materials sent to you in large print