<COMPANY LOGO> <Blue MedicareRx LOGO>

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date:
Enrollee Name:
Address:

Phone:

Medicare Health Insurance Claim #:
(from red, white and blue Medicare card)

Name of Medicare Prescription Drug Plan:

Please check all boxes that apply to you.	Dates of Coverage (month/year)
I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP) Name:_______________________________________	From: ____________ To: ____________
I had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state Name of SPAP:______________________________ If you are in an SPAP, what state do you live in: ____	From: ____________ To: ____________
I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits)	From: ____________ To: ____________
I had prescription drug coverage through my TRICARE or other military coverage	From: ____________ To: ____________
I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage	From: ____________ To: ____________

* "Creditable" means that your prior coverage met Medicare's minimum standards.

I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U)	From: ____________ To: ____________
I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly)	From: ____________ To: ____________
I had creditable* prescription drug coverage from a different source not listed above. Name of other source: ________________________	From: ____________ To: ____________
I have/had extra help from Medicare to pay for my prescription drug coverage.	From: ____________ To: ____________
I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: _____________________________	From: ____________ To: ____________
I never had creditable* drug coverage	

Please complete this section: “To the best of my knowledge, the information on this form is true and correct. I understand that if I didn’t have creditable coverage and/or don’t give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. 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 Blue MedicareRx by Medicare.”

Signature: ____

Date: *(month/day/year):* __________/__________/__________

If you are the representative, you must provide the following information:

Name: ____

Address: ____

City: _______________________________________ State: ____________ Zip: ____________

Phone Number: (______) __________- ______________

Relationship to Enrollee: ____

<STATE LICENSING STATEMENT>

Anthem Insurance Companies, Inc. (AICI), Blue Cross Blue Shield of Massachusetts, Blue Cross and Blue Shield of Vermont, and Blue Cross & Blue Shield of Rhode Island are the legal entities who have contracted with the Centers for Medicare & Medicaid Services (CMS) to offer the Part D plan(s) noted and are the risk-bearing entities for Blue MedicareRx plans.

<STATE LEGAL LINES>