# PRESCRIPTION ENROLLMENT FORM
# INDEPENDENT BUSINESS OWNERS BENEFITS ASSOCIATION

**ENROLLMENT IN THIS PRESCRIPTION PLAN WILL REPLACE ANY OTHER MEDICARE D PRESCRIPTION PLAN YOU ARE ENROLLED IN.**

| COMPLETE ALL QUESTIONS BELOW: | COMPLETE IF YOU HAVE A SPOUSE ELIGIBLE FOR BENEFITS: |
|---|---|
| **IBO Last Name** **First Name** **Middle Initial** | **Spouse Last Name** **First Name** **Middle Initial** |
| **Address (no P.O. Box)** **City** **State** **Zip Code** | **Address (no P.O. Box)** **City** **State** **Zip Code** |
| **Mailing Address** **City** **State** **Zip Code** | **Mailing Address** **City** **State** **Zip Code** |
| **Phone** | **Phone** |
| **Social Security #** | **Social Security #** |
| **Date of Birth** | **Date of Birth** |
| **Gender** ☐ **M** ☐ **F** | **Gender** ☐ **M** ☐ **F** |
| Please complete using your Medicare Card.<br>MEDICARE HEALTH INSURANCE<br>SAMPLE ONLY<br>Name: ____________<br>Medicare Claim Number ___ - __ - ____ Sex ___<br>Is Entitled To / Effective Date<br>HOSPITAL (Part A) ________<br>MEDICAL (Part B) ________ | Please complete using your Medicare Card.<br>MEDICARE HEALTH INSURANCE<br>SAMPLE ONLY<br>Name: ____________<br>Medicare Claim Number ___ - __ - ____ Sex ___<br>Is Entitled To / Effective Date<br>HOSPITAL (Part A) ________<br>MEDICAL (Part B) ________ |
| **IBO # (must be a current member to enroll)** ____________ **IBO Pin Level** ____________ | **E-mail address:** ____________ |
| **I wish to elect the following IBOBA Plans:**<br>☐ **Medicare D Prescription** | **I wish to elect the following IBOBA Plans:**<br>☐ **Medicare D Prescription** |

**OTHER HEALTH INSURANCE: Are you or anyone named above covered by another Prescription Insurance?** ☐ **Yes** ☐ **No**

| Signature | Date | Signature | Date |
|---|---|---|---|
| | | | |

**RELEASE OF INFORMATION AUTHORIZATION:** My signature authorizes Varipro to release or obtain any information, medical or other, which may be necessary to properly administer this Plan. A copy of this release will carry the same authority as the original. This applies to my covered dependents and myself. I understand my information will remain strictly confidential.

**FOR OFFICE USE ONLY:** **EFFECTIVE DATE** ____________ **RETIREE COST: $**____________ **STIPEND AMOUNT: $**____________

Form 1 Rev 2/17/2008