MEDICARE SUPPLEMENT/PRESCRIPTION ENROLLMENT FORM
INDEPENDENT BUSINESS OWNERS BENEFITS ASSOCIATION

ENROLLMENT IN THESE PLANS REQUIRES ACTIVE IBO MEMBERSHIP AT THE TIME OF APPLICATION AND REPLACES 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	Please complete using your Medicare Card.	**Phone**	Please complete using your Medicare Card.
Social Security #	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date HOSPITAL (Part A) _____ MEDICAL (Part B) _____	**Social Security #**	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date HOSPITAL (Part A) _____ MEDICAL (Part B) _____
Date of Birth		**Date of Birth**	
Gender ☐ **M** ☐ **F**		**Gender** ☐ **M** ☐ **F**	
IBO # (must be a current member to enroll) _____ **IBO Pin Level** _____		**E-mail address:** _____	
I wish to elect the following IBOBA Plans: ☐ **Medicare Supplement Plan A with Administration** ☐ **Medicare Supplement Plan B with Administration** ☐ **Medicare Supplement Plan F with Administration** ☐ **Medicare D Prescription**		**I wish to elect the following IBOBA Plans:** ☐ **Medicare Supplement Plan A with Administration** ☐ **Medicare Supplement Plan B with Administration** ☐ **Medicare Supplement Plan F with Administration** ☐ **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: $**_____