NEW YORK STATE OF OPPORTUNITY. | NY Power Authority

Salaried Retirees Medicare Part D Opt-In Form

When you become eligible for Medicare, you must enroll in Medicare Part A and Medicare Part B in order to participate in NYPA's retiree medical and prescription drug coverage. New York Power Authority (NYPA) will enroll you in **Express Scripts Medicare® (PDP) for New York Power Authority** for your prescription drug coverage.

Please complete the information below, sign the form and send it to NYPA, along with a copy of your red, white and blue Medicare Health Insurance card.

By signing below, I agree to the following:

I choose to receive the NYPA retiree prescription drug coverage through Express Scripts Medicare for New York Power Authority. I understand that I must be enrolled in Medicare Part A and/or Medicare Part B in order to be enrolled by NYPA in Medicare Part D.

I understand that if my Medicare Part D enrollment cannot be processed, or I am later disenrolled from the plan, I will lose my prescription drug coverage from NYPA. I may re-enroll in the plan in the future, but I may not change my election during the year unless I experience a qualifying event and call the NYPA Benefits Hotline within 30 days of the event.

By agreeing to be enrolled in a Medicare Part D plan, I acknowledge that Express Scripts Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.

The information provided on this form is correct to the best of my knowledge. I understand that I may be dis-enrolled from the plan if I intentionally provide false information as part of my enrollment.

Participant (Retiree, Spouse or Dependent) _____ Date of Birth (mm/dd/yyyy) _____

Medicare Claim Number (from Red, White and Blue card) _____ Medicare Effective Date _____

E-Mail Address _____ Daytime Telephone Number _____

Permanent Residence/Long-Term Care Facility & Street Address – Medicare does not allow a P.O. Box _____

City _____ State _____ Zip Code _____

Participant Signature (Retiree, Spouse or Dependent) Type your name _____ Date _____

☐ Please check if the person signing above is the authorized representative for the Retiree, Spouse or Dependent.

Name of Authorized Representative (First and Last) _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

Relationship to Retiree:

☐ Child ☐ Spouse ☐ Friend ☐ Other (please specify) _____

Please return this form at least 30 days before your coverage effective date to NYPA via e-mail to HR.Services@nypa.gov or mail to NYPA, Benefits Department, 123 Main Street, White Plains, NY 10601.