

## Enrollment Form

Please fill out and carefully read all information before signing and dating the enrollment form. **You must complete one form for each eligible family member who wishes to re-enroll.**

Please fax or mail this form to the Plan for processing. Our fax number is 571-599-7475. Our mailing address is:

NALC Health Benefit Plan  
20547 Waverly Court  
Ashburn, VA 20149

|                  |            |                                    |                                                                                                                       |
|------------------|------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Last Name        | First Name | Middle initial                     | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. |
| NALC Member ID   |            | Medicare ID                        |                                                                                                                       |
| Birth Date       |            | Home/Cell Phone Number<br>(      ) |                                                                                                                       |
| Physical Address |            | Mailing Address (if different)     |                                                                                                                       |

By completing this enrollment request, I agree to the following:

SilverScript will notify me of my enrollment date after they receive this form. Until I receive my SilverScript Welcome Kit with new ID cards, I will continue to use my current NALC HBP Member ID Card for prescription purchases.

Signature:\* \_\_\_\_\_ Date: \_\_\_\_\_

- \* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 Medicare.

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (      ) \_\_\_\_ - \_\_\_\_ Relationship to Enrollee: \_\_\_\_\_