



**Blue Shield
of California**

An Independent Member
of the Blue Shield Association

**Affirmative Declination of Employer-Provided
Medicare Part D Prescription Drug Coverage**

Group Name _____

Group # _____

By signing below, you are affirmatively declining, or ‘opting-out’ of, Medicare Part D prescription-drug coverage under the Blue Shield of California Medicare Rx Plan offered by your employer, _____ . If you have a spouse or Domestic Partner, he or she will also be excluded from this prescription-drug coverage. If you have a child or children, he, she, or they will be excluded from your employer’s plan. If you later decide to seek prescription-drug coverage from your employer, that coverage may not be available until your next open-enrollment period, if at all. Visit your employer’s website or ask your employer how your decision to decline employer-provided prescription-drug coverage will affect your future coverage eligibility.

Even if you don’t use many prescription drugs now, you may still wish to consider a Medicare prescription-drug plan independent of your employer’s plan. Joining a Medicare prescription- drug plan by May 15, 2006 means that you will avoid future penalties for late enrollment. If you don’t join a plan and you do not otherwise have prescription-drug coverage that is as good as or better than the Standard Medicare Prescription Drug Benefit, you will pay a penalty for such coverage in the future. Your monthly Medicare Part D premium will increase at least 1% for every month that you wait to enroll in a Medicare prescription-drug plan. There is no cap on this penalty. For more information on Medicare prescription-drug plans, please visit <http://www.medicare.gov> or contact Blue Shield of California Medicare Rx Plan Customer Service at (888)-239-6469, Monday through Friday, 8:00 a.m. to 5:00 p.m. (excluding holidays). TTY/TDD users should call (888)-239-6482.

Your coverage under Medicare Part A or Part B will not be affected if you do not have coverage under Medicare Part D or other prescription drug coverage.

* * *

With my signature below, I affirmatively decline Medicare Part D prescription-drug coverage under the Blue Shield of California Medicare Rx Plan offered by my employer, _____.

Print Name: _____

Signature: _____

Subscriber number: _____

Date: _____

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