MoRx Enrollment Form

To receive benefits, you must live in Missouri and be in a Medicare Part D prescription drug plan. Do **not** send this form if you are in MO HealthNet (formerly Missouri Medicaid) or if an employer-sponsored plan pays for your prescription drugs.

1. Personal information

Last name: | First name: | Middle initial:

Date of birth: / / | Sex: Female ☐ Male ☐ | Phone number: ( )

SSN: – – | MEDICARE claim number:
(Social Security Number) | (The number on your red, white & blue Medicare Health Insurance card)

Name of your Medicare Part D prescription drug plan:

Residence address: | Apt/Lot No:

City: | State: | Zip code: | County:

Mailing address (complete **only** if you want your mail sent to a different address):

Last name: | First name: | Middle initial:

Address: | Apt/Lot No:

City: | State: | Zip code:

2. Race/ethnicity (check all that apply)

☐ White ☐ African-American ☐ Hispanic ☐ Asian ☐ Nat. Hawaiian/Pacific Island ☐ Amer. Indian/Alaskan Native

3. Check the ONE box that best describes your INCOME. Information is required for MoRx eligibility.

Single, widowed, divorced or live apart from my spouse and:
- ☐ My annual gross income is less than $15,600 *
- ☐ My annual gross income is between $15,600 and $20,800

Married and:
- ☐ Our annual gross income is less than $21,000 *
- ☐ Our annual gross income is between $21,000 and $28,000

4. Check the ONE box that best describes your LIQUID ASSETS. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions. **This information is required but does not affect your MoRx eligibility.**

Single, widowed, divorced or live apart from my spouse and:
- ☐ My assets are $11,990 or less *
- ☐ My assets are greater than $11,990

Married and:
- ☐ Our assets are $23,970 or less *
- ☐ Our assets are greater than $23,970

* You may also be eligible for extra help with Medicare Part D costs. Call the Social Security Administration at 1-800-772-1213 to get an application.

5. Sign and date

You must sign this form. If you cannot sign, a representative may sign for you.
I certify and attest that I am a resident of the State of Missouri and that the answers to the questions on this form, the items on the form and the submitted required documentation are true and accurate. I understand that the MoRx Plan may check it against other government records or require additional proof from me at any time.

Sign:..... Date:.....

Check the appropriate box: ☐ Applicant ☐ Representative

MoRx 03/08

6. You must enclose a COPY of your Social Security card and your Medicare Health Insurance card with your application. Mail to: MoRx Plan, PO Box 208, Troy, MO 63379.