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.

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: ____

PDP00039 (11/05)