MEDICARE OPEN ENROLLMENT is October 15th to December 7th Fax completed form to: 701-328-9610 or email to: ndshic@nd.gov

Do you use mail order?

No

Yes

STATE HEALTH INSURANCE PROGRAM (SHIP) DISCLOSURE STATEMENT/AGREEMENT SHIP Counselors, trained by the North Dakota Insurance Department, are acting in good faith to provide independent, impartial information about health insurance policies and benefits to beneficiaries. Counselors do not sell any type of health care coverage, nor do they endorse or recommend any specific plan or policy. Any information presented by SHIP volunteers or staff should not be construed to be legal advice, and volunteers are not liable for acts and omissions in providing counseling to recipients of service. If you have chosen to make a change to your Medicare Part D plan and are asking SHIP volunteers for assistance to make changes on your behalf, you will be required to give verbal consent acknowledging your request. You will be responsible for the actual plan contract of that enrollment. The SHIP counselor will NOT choose a plan for you. Applicant Signature Date Applicant's Representative Signature (if applicable) Date **APPLICANT INFORMATION** Name of Applicant (First, Middle, Last) Age of Applicant ZIP Code Address City State Telephone Number **Email Address** County How did you hear about SHIP? Primary Language Spoken I am interested in reviewing my Part D Drug Plan? I am interested in reviewing my Advantage Plan? Yes Yes Do you currently have other insurance coverage? If Yes, Specify Insurance Company Yes No FINANCIAL ASSISTANCE PROGRAM INFORMATION Mark the services you are currently receiving Extra Help Medicaid Medicare Savings Plan **DRUG PLAN** Name of Current Drug Plan Name of Current Drug Plan Company PHARMACY INFORMATION Name of Preferred Pharmacy Name of Alternative Pharmacy

SFN 61886 (9-2023) Page 2 of 2 PRESCRIPTION AND PHARMACY INFORMATION Provide information about your prescribed medications only. NOTE: You may be able to obtain a computerized listing from your pharmacy to attach. If not, complete the chart below. Attach additional sheets if needed. Check this box if you don't take any medication. Name of Drugs Strength Daily Dose/Monthly Dose Example: Lipitor Example: 10 mg Example: Twice Daily If no appointment is needed and you prefer your comparisons to be emailed or mailed to you, indicate below: APPLICANT'S AGREEMENT, AUTHORIZATION, AND WAIVER OF LIABILITY I understand the SHIP counselor may assist me with creating a Mymedicare gov account in order to assist with enrolling into a Prescription Drug Plan, Part D. The information provided for the Mymedicare.gov account is not retained by the counselor . I certify that I provided to the SHIP counselor the information necessary to complete the forms and further certify that the information I provided is true and correct to the best of my knowledge. Counselors do not sell, recommend or endorse any specific insurance product, agent or company nor do they decide which plan is best. I agree that it is my sole responsibility to select the best plan based on the information provided and that I requested enrollment in the selected plan or prefer to enroll myself. Counselors assume no responsibility for decisions made by or actions taken by me. I agree to waive any claims I may have against and hold harmless the (SHIP) Program, the State of North Dakota and the counselor or affiliated agency for any liability arising out of services provided. I agree that I will not hold the SHIP program, the State of North Dakota or its management, employees and volunteers responsible for the denial of benefits or the wrongful receipt of benefits as a result of the health benefit plan chosen by me. I have read this document fully and carefully and am voluntarily choosing to acknowledge this agreement. **Applicant Signature** Date Applicant's Representative Signature (if applicable) Date FOR OFFICE USE ONLY Created a Medicare.gov Account Name of Counselor/Volunteer Time Spent on Intake Yes No Current Plan Name **Annual Cost** New Plan Name **Annual Cost**

Enrolled

Yes

No

Total Part D Savings

Enrollment Confirmation Number