

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: - - (Social Security Number)	MEDICARE claim number: (The number on your red, white & blue Medicare Health Insurance card)			
Name of your Medicare Part D prescription drug plan:				

Residence address:

City:	State:	Zip code:	County:
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Mailing address (complete **only** if you want your mail sent to a different address):

Last name:		First name:		Middle initial:
Address:				
City:	State:	Zip Code:		

2. Race/ethnicity (check all that apply)

White African-American Hispanic Asian Nat. Hawaiian/Pacific Island American 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 \$16,245* My annual gross income is between \$16,245 and \$21,660	Married and: Our annual gross income is less than \$21,855* Our annual gross income is between \$21,855 and \$29,140
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4. Check the ONE box that best describe 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 \$12,510 or less* My assets are greater than \$12,510	Married and: Our assets are \$25,010 or less* Our assets are greater than \$25,010
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* 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



Cut at the line and keep the bottom portion for your records.

Important: Send one **copy** of your Medicare Health Insurance Card and one **copy** of your Social Security Card with your **signed** enrollment form to: MORx Plan, PO Box 6500, Jefferson City, MO 65102. Do **not** send originals.

1. Send a **copy** of your Medicare Health Insurance Card



2. Send a **copy** of your Social Security Card

