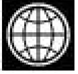

# F200021 U.S. National Health Plan (Medicare) Transmittal Form

World Bank Group UPI << Type UPI here

**Instructions:**
1. Complete all fields. Print using the button at the bottom of the form.
2. Date and sign the form in ink.
3. Submit with a **copy of the Medicare ID card** for the Retiree or the Spouse/Domestic Partner (including those in receipt of survivor spouse pensions).
4. Return this form to HR Operations. (Please select one transmittal format, and submit only once):
   a. Fax +1 (202) 522-7026
   b. E-mail at hroperations@worldbank.org
   c. Mail to: HR Operations, World Bank MSN G2-202, P.O.Box:1420, Landover MD 20785, USA

**Note: This form will not be accepted without a copy of the Medicare ID card**.

| Member Name: | | |
|---|---|---|
| Electronic Email Address : | | Home Telephone Number |
| US Street address of Primary Residence (or Long-term Care Facility); (Medicare does not allow a P.O. Box) | | |
| City: | State | ZIP code |

**By checking the first box and providing the information requested above, you will be enrolled in SilverScript Employer Prescription Drug Plan (PDP) sponsored by the World Bank Group for Medicare Part D prescription drug coverage.**

☐ I choose to enroll in the SilverScript Employer PDP sponsored by the World Bank Group. I understand I will be automatically enrolled in Medicare Part D by SilverScript. I also understand that if I'm eligible for Medicare Part D and choose not to enroll in SilverScript, I will lose all prescription drug coverage from the World Bank Group. If I am the retiree, I further understand that my covered dependent(s) will also lose their coverage.

*By agreeing to be enrolled in a Medicare Part D plan, I acknowledge that SilverScript will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the plan will release my information, including my prescription drug event data, to Medicare, which may release it for research and other purposes which follow all applicable federal statutes and regulations.*

☐ I choose NOT to enroll in the SilverScript Employer PDP sponsored by the World Bank Group prescription drug coverage. I understand that I, and my covered dependent(s), will lose the World Bank Group prescription drug coverage.

| Member Signature | | | Date | |
|---|---|---|---|---|
| ☐ Please check here if you are the authorized representative for the Member. | | | | |
| Name of Authorized Representative | | | Phone | |
| Address | City | State | ZIP code | |

Relationship to Retiree or Dependent: ☐ Child ☐ Spouse ☐ Friend ☐ Other (please specify)

**Please ensure ALL information in this submission form is complete and accurate before printing the form** >>