SilverScript®

Enrollment Form

Please fill out and carefully read all information before signing and dating the enrollment form. You must complete one form for each eligible family member who wishes to re-enroll.

Please fax, upload to the NALC HBP Member Portal or mail this form to the Plan for processing. Our fax number is 571-599-7475. Our mailing address is:

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

Last Name First Name Middle initial	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
NALC Member ID	Medicare ID
Birth Date	Home/Cell Phone Number ( )
Physical Address	Mailing Address (if different)

By completing this enrollment request, I agree to the following:
SilverScript will notify me of my enrollment date after they receive this form. Until I receive my SilverScript Welcome Kit with new ID cards, I will continue to use my current NALC HBP Member ID Card for prescription purchases.

Signature:*_____ Date: _____

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Medicare.

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____ - _____ **Relationship to Enrollee:** _____