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3261 Senior Rx
Dept. of Human Resources
Director's Office, Room 600
Carson City, Nevada 89701-3708



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 17 CARSON CITY NV

POSTAGE WILL BE PAID BY ADDRESSEE

STATE OF NEVADA
SENIOR RX
P.O. BOX 21230
CARSON CITY NV 89721-9909



www.nevadaseniorrx.com

**NEVADA'S
SeniorRx**
*Providing insurance subsidies
for qualifying seniors*



SeniorRx
may be the solution!
Apply Now!

Do you need help
paying your
medicine bills?

Seniors...

ORIGINAL EXHIBIT ON FILE AT THE
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ASSEMBLY HEALTH AND HUMAN SERVICES
DATE: 2/12/03 ROOM: 3130 EXHIBIT E-1 of 4
SUBMITTED BY: Jane Smedes

NEVADA'S seniorRx

The State of Nevada will provide insurance subsidies allowing you to obtain prescription medicines at significant discounts if you qualify:

- Age 62 or older
- Nevada resident for at least one year
- Not eligible for low-income Medicaid assistance
- Household income not over \$21,500

The Benefits to You:

- No Premium
- No Deductible
- Copayments of \$10 or \$25

If you think you qualify complete the attached application and drop in any mail box. No postage necessary.

For more information:

1-800-262-7726

www.nevadaseniorrx.com

Nevada Department of Human Resources

Application for the State of Nevada • Prescription Insurance Subsidy Program

Form SR RX 7/01

Tear along this perforation. Fold up completed application form, moisten glue strip and apply to edge indicated.

1. Applicant: ☐ M ☐ F Last Name, First, MI Birthdate Social Security #

2. Spouse: ☐ M ☐ F Last Name, First, MI Birthdate Social Security #

Is spouse applying for a subsidy? Yes ☐ No ☐

3. Residence Address: Number, Street, Apt or Space Number, City/Town, State, Zip

4. Mailing Address: Number, Street, Apt or Space Number, City/Town, State, Zip

5. Telephone Number: ()

6. Did you live in Nevada continuously 12 months prior to the date of this application?
Applicant: Yes ☐ No ☐ Spouse: Yes ☐ No ☐

List all current income received

Spouse must list monthly income even if not applying for the prescription insurance subsidy program.

	Applicant	Spouse	Total
7. Social Security (less Medicare).....	\$ +	\$ +	=
8. SSI (Supplemental Security Income) \$	\$ +	\$ +	=
9. Pensions/IRAS.....	\$ +	\$ +	=
10. Interest/Dividends.....	\$ +	\$ +	=
11. Wages.....	\$ +	\$ +	=
12. Net Real Estate Rental Income.....	\$ +	\$ +	=
13. Other (describe).....	\$ +	\$ +	=
Total Applicant & Spouse Monthly Income.....	\$ +	\$ +	=
14. Capital Gains (Loss) last year.....	\$ +	\$ +	=
15. Business Income (Loss) last year.....	\$ +	\$ +	=

Please provide monthly income, not annual income (except lines 14 and 15).
(Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for the purposes connected with the administration of this program.)



Outpatient Prescription Drug Insurance Enrollment Form

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO. Policy No. PD-155

Please complete enrollment form by typing or printing in ink.

**Each applicant must complete and sign the member information section.
If spouse is applying also, complete this member information section.**

State of Nevada Senior Rx Prescription Drug Plan

Member's Name: _____
Social Security Number: ____/____/____
Address: _____
City: _____
State: _____ Zip: _____
Date of Birth ____/____/____ Sex: ☐ Male ☐ Female
Month Day Year
Phone Number: (____) ____-____

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of America Group Insurance Trust. The Trust is not the insurance company and has no responsibility for this insurance except to hold the master policy.

I understand and agree that the statements and answers in the application are complete and true as of the date I signed this application, and that this application becomes part of the contract of insurance. I also understand and agree that the insurance, if issued, will take effect on the effective date stated in the certificate provided this application has been accepted by the Company, the first premium has been paid in full, and that I am alive on the effective date.

Signature: _____ Date: _____

A-00935

**Each applicant must complete and sign the member information section.
If spouse is applying also, complete this member information section.**

(Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for the purposes connected with the administration of this program.)

M-9022 07/01

Managed By: PRAM Insurance Services • 711 E. Imperial Hwy., Suite 100 • Brea, CA 92821 • 800-262-7726

Requirements

- A. Age:** Applicant and spouse (if spouse is also applying) must be 62 years of age at the date of application.
- B. Income:** Includes income from all sources for both applicant and spouse. Total combined applicant and spouse income must be \$21,500 per year or less.
- C. Residency:** Applicants must have lived continuously in Nevada for at least one year (12 consecutive months) prior to the date of application.
- D. Eligibility for SSI/Medicaid:** If you are eligible for SSI (Supplemental Security Income) in Nevada, you are also eligible for full Medicaid benefits, including prescription coverage, at no cost to you. Please contact the Social Security Administration at 1-800-772-1213 if you believe your situation matches one of the following:
- 1) Single person, under age 65 and disabled, annual income of less than \$6,400, limited assets.
 - 2) Single person, age 65 or older, annual income of less than \$6,900, limited assets.
 - 3) Single person, blind, annual income of less than \$7,700, limited assets.
 - 4) Married couple, age 65 or older, annual household income of less than \$10,500, limited assets.

Important information about your application

- A.** You do not need to attach income or age verification to this application. However, you may be asked to provide such documentation at a later date.
- B.** Married couples need to submit only one application for both spouses.
- C.** You will be notified of eligibility status within 21 days of receipt of your application, unless the Department of Human Resources needs to request additional information to process your application.
- D.** Mail completed applications to:
**State of Nevada
Senior Rx
P.O. Box 21230
Carson City, NV 89721-9909**

Attach glue edge to this edge.

17 07 4

Please read and sign below before completing this application.

By signing this application, I agree to the following:

- To immediately provide to the Department of Human Resources written notice of a change of address, name, household income, marital status, telephone number and Medicaid or SSI eligibility.
- If I received the benefit of the Senior Rx subsidies and I was not eligible for the subsidy, I will refund to the Department of Human Resources all amounts paid on my behalf.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize the Department of Human Resources to verify my eligibility including my income. This authorization is valid for a period of fourteen months from the date of my signature below.

I declare that the information in this application for the Senior Rx program is accurate to the best of my knowledge and ability.

Applicant Signature

Print Name Date

Spouse Signature

Print Name Date

Please note: If someone other than the applicant/spouse signs, a copy (non-returnable) of a Power of Attorney or Letters of Guardianship must be attached.



Outpatient Prescription Drug Insurance Enrollment Form

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO. Policy No. PD-155

Please complete enrollment form by typing or printing in ink.

Each applicant must complete and sign the member information section. If spouse is applying also, complete the second member information section on the back.

State of Nevada Senior Rx Prescription Drug Plan

Member's Name: _____
Social Security Number: _____ / _____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth _____ / _____ / _____ Sex: ☐ Male ☐ Female
Month Day Year
Phone Number: (____) _____ - _____

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the United Associations of America Group Insurance Trust. The Trust is not the insurance company and has no responsibility for this insurance except to hold the master policy.

I understand and agree that the statements and answers in the application are complete and true as of the date I signed this application, and that this application becomes part of the contract of insurance. I also understand and agree that the insurance, if issued, will take effect on the effective date stated in the certificate provided this application has been accepted by the Company, the first premium has been paid in full, and that I am alive on the effective date.

Signature: _____ Date: _____

A-00935

Each applicant must complete and sign the member information section. If spouse is applying also, complete the second member information section on the back.

(Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for the purposes connected with the administration of this program.)

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