Exhibit 2: Medicare Prescription Payment Plan Participation Request Form

***[Instructions:** The 'Medicare Prescription Payment Plan Participation Request Form' lets a beneficiary notify the Part D sponsor that they would like to participate in the payment option.*

This model form satisfies the requirement for Part D sponsors to provide Part D enrollees with an election request form to participate in the Medicare Prescription Payment Plan and meets all the communication requirements outlined in Section 30.3 of the "Medicare Prescription Payment Plan: Final Part Two Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Response to Relevant Comments." Plan sponsors may add their logos to brand this document.

*If a Part D sponsor gets a form that it is not complete, the sponsor must contact the individual to ask for more documentation. Part D sponsors may consider a form complete if it has the **enrollee's name, Medicare number, and has been signed by the enrollee or their authorized representative.** Part D sponsors may also add a field for plan-specific beneficiary identification numbers to assist with plan processing of enrollment requests.*

Italicized blue text in square brackets is information for the plans and shouldn't be included in the request form. Non-italicized blue text in square brackets may be inserted or used as replacement text in the request form. Use it as applicable.]

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). **This payment option may help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Complete all fields unless marked optional

FIRST name:	LAST name:	MIDDLE initial (optional):
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _		
Birth date: (MM/DD/YYYY) (_____/_____/_____)	Phone number: ( )	

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

City:	County (optional):	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):
Address: City: State: ZIP code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. [Plan Name] will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form *[*and the attached terms and conditions *(insert if the terms and conditions are included with this form)]*.

- **[Plan Name] will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature:	**Date:**

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name:	Address (Street, City, State, ZIP code):
Phone number: ( )	Relationship to participant:

How to submit this form

[Plan may insert their instructions for submitting the participation request online, over the phone, or by mail.]

Submit your completed form to:

[Plan Name]
[Plan address]
[Plan address]
[Plan address]
[Plan fax number *if applicable*]
[Plan email *if plan chooses to accept forms via email*]

You can also complete the participation request form online at [website link], or call us at [phone number] to submit your request via telephone.

If you have questions or need help completing this form, call us at [phone number], [days and hours of operation]. TTY users can call [TTY number].

[Plans can insert their Medicare Prescription Payment Plans terms and conditions on the back of this form or attach them separately.]