[DATE]

[(if F108=M, populate)F101]

[(if F108=L, populate)F109]

[F8] [F9] [F10]

[F102]

[F103]

[F104], [F105] [F106]-[F107]

Re: Other Prescription Drug Coverage

Dear [F8] [F10]:

Thank you for enrolling in the [PlanName] plan for your Medicare Part D coverage. At   
the time of your enrollment you indicated that you had other prescription drug coverage. After reviewing your enrollment request, we find it necessary to get additional information from you regarding your other prescription drug coverage.

To ensure you receive your full benefits, please contact our Customer Care department to provide the missing information. You can find this information on your insurance carrier’s ID card. Please have your insurance ID card with you before you call.

You can reach Customer Care at 1-866-824-4054, [CustomerCareHours].TTY users should   
call [CustomerCareTTY]. One of our trained representatives will be happy to assist you.

Sincerely,

Your SilverScript Benefits Team

Your privacy is important to us. SilverScript employees are trained regarding the appropriate way to handle your private health information.