Oleg Skurskiy Authorized Independent Agent, CA License 0E50389
licensed in State of California , Colorado , Texas , Virginia , Arizona ,
Nevada , Illinois , Ohio, Georgia, Connecticut, New Hampshire

Please print out the form below and mail your completed form to:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356
or
By fax at 1-818-776-9865

Please do not send application to above fax or address the application if you are outside of the states below.

State of California , Colorado , Texas , Virginia , Arizona , Nevada ,
Illinois , Ohio, Georgia, Connecticut, New Hampshire .

all other states please call medicare at 1-800-medicare

Anthem Blue Cross and Blue Shield
SmartValue

Medicare Advantage PFFS Individual Enrollment Request Form — 2009

Be sure to complete all four pages of the enrollment form and return it to:
OLEG SKURSKIY 18375 VENTURA BLVD # 226 TARZANA, CA 91356 OR BY FAX 818-776-9865

Section 1: Please provide information about you. (Please print clearly.)

Last Name	First Name	Middle Initial

Permanent residence street address (cannot use P.O. Box)	City	County

State	ZIP Code	Phone No. ( )	Alternate Phone No. ( )	Social Security No. (optional)	Sex ☐M ☐F	Date of Birth

Mailing/Billing Address (if different from address above)	City	State	ZIP Code

Section 2: Benefit Plan Selection

Note to Applicant: For information about the service areas and the premiums of the Medicare Advantage Private-Fee-for-Service plans available to you, please refer to the Summary of Benefits provided with your enrollment materials.

I wish to enroll in the plan checked below:

☐ SmartValue Plus — This plan includes Medicare Part D prescription drug coverage.

☐ SmartValue Classic — This plan does not include Medicare Part D prescription drug coverage. To enroll in Medicare Part D prescription drug coverage, you must purchase a separate Medicare Part D plan.

Section 3: Please provide your Medicare Insurance information.

Please take out your Medicare Card to complete this section.

- Please fill in the blanks at right so they match your red, white and blue Medicare card.

-or-

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have both Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

Name _____

Medicare Claim Number Sex ____

__ __ __ - __ __ - __ __ __ __

Is Entitled To: Effective Date:

Hospital (Part A) _____

Medical (Part B) _____

Section 4: Please indicate if you prefer information in another language or format.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ In Spanish. (To see if materials in Spanish are available for your plan, please call Customer Service at the phone number shown in the enclosed Summary of Benefits.)

☐ In large print

If you need more information about materials in a format other than shown above, call Customer Service at the phone number shown in the enclosed Summary of Benefits.

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al numero telefónico que se muestra en el material adjunto.

Section 5: Paying Your Plan Premium.

If you are enrolling in a plan without any premium: If the plan includes Medicare Part D prescription drug coverage, and we determine that you owe a late enrollment penalty for the Part D portion of your plan, we need to know how you would prefer to pay it. Please choose one of the payment options in the checklist below.

If you are enrolling in a plan with a monthly premium, how would you like to pay future plan premiums? You can pay your monthly plan premium by mail or by automatic bank account deduction. You might also be able to pay your premium by automatic deduction from your Social Security Check each month *(see below)*.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or some portion of your plan premium. However, because you might be responsible for paying part of your premium, you still must choose a premium payment option. We must receive payment for the amount that Medicare does not cover.

Please choose one of the payment options below: *(If no option is chosen, you will receive a monthly bill for the amount due.)*

☐ Monthly Bill: Send me a bill each month.

☐ Automatic Bank Account Deduction: Deduct the amount from my bank account each month. *(Depending on when you apply, more than one month's amount might be deducted for your **first** payment.) Please complete steps 1, 2 and 3 below:*

1) Account type: ☐ Checking: Enclose a VOIDED check

2) Please complete the following information for your account:
Account Number: _____ Account Holder Name: _____ Bank Name: _____

Bank Routing Number: _____ *(This is the first 9 digits printed on the lower left corner of your check.)*

3) ☐ I authorize the bank above to allow this monthly deduction of the amount from the account above.

☐ Automatic Social Security Deduction: Deduct the amount from my Social Security benefit check each month. *(If you choose this option, your monthly Social Security check should be at least 3 times your monthly premium. The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date to the date withholding begins.)*

Section 6: Please Answer the Following Questions:

1. Do you have End Stage Renal Disease (ESRD)? . . . . . ☐ Yes ☐ No
   Generally, if you answered *"**Yes**,"* you are not eligible to enroll in this plan. However, if you answered *"Yes"* to this question but you no longer need regular dialysis or have had a successful kidney transplant, **please attach a note or records from your doctor** stating this.

Please complete question 2 only if you are applying for a plan with Medicare Prescription Drug coverage:

2. In addition to SmartValue, will you have other prescription drug coverage, such as *other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs*? ☐ Yes ☐ No
   If ***"Yes,"*** please list the name(s) of your other coverage and your identification (ID) number(s) for this coverage below.
   Name of coverage _____ ID no. _____ Group no. _____
3. Do you or your spouse work? . . . . . ☐ Yes ☐ No

Section 7: Important — Please read.

SmartValue, a Medicare Advantage Private-Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at www.anthem.com/medicare.

Once Anthem Blue Cross and Blue Shield (Anthem) has received your enrollment form, you will receive a call from a plan representative. This call is to make sure that you understand how a Private-Fee-for-Service plan works and to confirm your intent to enroll in SmartValue. If Anthem is not able to reach you by telephone, then you will receive a letter by mail that contains similar information.

Please read if you are applying for a plan with Medicare Prescription Drug coverage: **If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining this plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 8: Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage (MA) Plan only during the Annual Open Enrollment Period (AEP) from November 15 to December 31 of each year. You can also join an MA plan during the MA Open Enrollment Period (MA-OEP) from January 1 to March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions — i.e., Initial Enrollment Period (ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in an MA plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)
- ☐ I am enrolling during the MA Open Enrollment Period from January 1 to March 31. (MA-OEP)
- ☐ I am newly eligible for Medicare. (ICEP)
  Eligibility Date: ___/___/_____ (Mo. / Day / Year)
- ☐ I recently moved and this plan is a new option for me.
- ☐ I recently returned to the United States after living permanently outside of the U.S. (SEP)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)
- ☐ I live in a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)
- ☐ I recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP)
- ☐ I recently moved outside of the service area of my current plan. (SEP) Date of move: ___/___/_____ (Mo. / Day / Year)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I receive extra help to pay for Medicare prescription drug coverage. (SEP)
- ☐ I am no longer eligible for extra help to pay for my Medicare prescription drug coverage. (SEP)
- ☐ I am involuntarily losing coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*
- ☐ I am voluntarily leaving coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*
- ☐ None of these statements applies to me.*

** To see if you are eligible to enroll, please contact us at the telephone number for Prospective Members shown in the enclosed Summary of Benefits.*

*If you qualify for an SEP and want a future effective date, please request here: Mo. _____ / Day **01** / Year _____*

Section 9: Application Agreement *Important:* Read this information before signing in Section 10 on next page.

By completing this enrollment application, I agree to the following:

The plan I am applying for is a Medicare Advantage Private-Fee-For-Service (PFFS) plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan, or a Medicare prescription drug plan if applicable. I am responsible for informing you of any prescription drug coverage that I have or may get in the future. If I am applying for a PFFS plan that does not include Medicare prescription drug coverage, I understand that I may obtain coverage from another Medicare prescription drug coverage plan. If I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

As a Medicare Private-Fee-For-Service plan, SmartValue works differently than a Medicare supplement plan. SmartValue pays instead of Medicare, and I will be responsible for the amounts that SmartValue does not cover, such as copayments and coninsurances. Original Medicare will not pay for my health care while I am enrolled in SmartValue.

Before seeing a provider, I should verify that the provider will accept SmartValue. I understand that my health care providers have the right to choose whether to accept a Private-Fee-For-Service plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept SmartValue, I will need to find another provider that will.

The plan for which I am applying serves a specific service area. If I move out of the area that this plan serves, I need to notify Anthem so I can disenroll and find a new plan in my new area. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I agree that the Evidence of Coverage (EOC) document governs the rules that I must follow to receive coverage in this Private-Fee-for-Service plan. When I receive the EOC document from Anthem, I will read it so I know the rules to follow. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or

Section 9 continues on next page

 For Applicant to Complete: Name _____ & Medicare ID#_____

files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Anthem, he/she may be compensated based on my enrollment in SmartValue. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the health plan 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, if applicable, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. ***Note:*** *Failure to agree with all of the terms and conditions in the Release of Information statement above will result in a denial of your enrollment due to an inability to provide benefits and process claims.*

Section 10: Signature

I understand that my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) means that I have read and understand the contents of this form and accompanying plan materials. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this form and 2) documentation of this authority is available upon request by Anthem or by Medicare.

Your Signature*	**Today's Date:**

**If you are the authorized representative of the applicant, you must sign above and provide the following information:*

Name	Phone no.	Relationship to enrollee	
Street Address	City	State	ZIP code

SMUFR1678AM 08/08 H0540, H1689

Applicant: Please Do Not Complete the Following Sections. *For Office and Agent/Broker Use Only.*

Office Use — *Internal Agents Only:* Name/Tax ID No. of staff member (if he/she assisted in enrollment):

Inside rep./ telemarketer: _____ / |___|___|___|___|___|___|___|___|___|___|

Field rep.: _____ / |___|___|___|___|___|___|___|___|___|___|

Signature: _____ Effective Date of Coverage _____ ***or*** ☐ Not Eligible

External Agents/Brokers Only:

Date received from applicant: _____

I helped the applicant fill out this application: ☐ Yes ☒ No

Please check the ID No. to use for commission payment:

☐ Agent/ Broker's Tax ID No.: |___|___|___|___|___|___|___|___|___|___|

☐ Agency Tax ID No.: |___|___|___|___|___|___|___|___|___|___|

External Agent/Broker's

Signature _____

Date _____

Please complete all lines below.

Agent/Broker's Printed Name: OLEG SKURSKIY

Agency Name: _____

Address 18375 VENTURA BLVD # 226
Street address

TARZANA, CA 91356
City *State* *ZIP code*

Phone No.: ( ) 818-654-4548

Fax No.: ( ) 818-776-9865

E-Mail Address: OLEG@ASKOLEG.COM

 For Applicant to Complete: Name _____ & Medicare ID#_____

Anthem Insurance Companies, Inc. (AICI) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Advantage Private Fee for Service (PFFS) plans noted above or herein. AICI is the state-licensed, risk-bearing entity offering these plans. AICI has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PFFS plans available in this region.