Office Use Only: Date Stamp

Anthem Blue Cross and Blue Shield Anthem Medicare Preferred Individual Enrollment Form — 2008

Please read the following:

- **Be sure to complete all three pages of the enrollment form. Return the original copy, *including this cover page,* to the address below:**

  Oleg Skurskiy
  18375 Ventura Blvd. # 226
  Tarzana , CA 91356

  Or fax the completed form to 1-818-776-9865

- **Also, be sure to complete the enclosed Working Aged Survey and return the original copy *along with your completed enrollment form.***

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. M0013_08_014 07/2007

These plans are PPOs with a Medicare contract.

In Nevada, Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

White Copy: Return to Anthem Yellow Copy: Applicant Should Keep Pink Copy: Agent/Broker

Section 1: Enrollee Data (Please print: Press firmly)

First Name	Middle Initial	Last Name

Home Street Address/Apt. No. (Cannot use P.O. Box)	City	County

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

Mailing 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 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:

☐ Anthem Medicare Preferred Premier

Important: This plan includes Medicare Part D prescription drug coverage.

Section 3: Health Insurance Card for Medicare 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: Paying Your Plan Premium

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 amount due.)*

☐ Send me a bill each month.

☐ Deduct my premium from my bank account each month. *(Depending on when you apply, more than one month's premium might be deducted for your **first** payment.)*

Account Type: ☐ Checking Account Number:_____

Please enclose a VOIDED check or provide the following information:

Account-Holder's Name: _____ Bank's Name: _____

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

☐ Deduct my premium from my SSA benefit check each month. *(If you choose this option, your monthly SSA check should be at least 3 times your monthly premium, because the SSA deduction may take two or more months to begin. So, the first deduction from your SSA benefit check may be for 2 or 3 months — from your effective date to the date withholding begins.)*

Section 5: Please Answer the Following Questions:

1. Do you have End Stage Renal Disease (ESRD) and/or receive routine kidney dialysis treatment? ..... ☐ Yes ☐ No
   If you have ESRD and/or need regular kidney dialysis, you cannot enroll in this plan unless you are already enrolled as a member of any Anthem Blue Cross and Blue Shield plan **or** unless your enrollment in another Medicare Advantage plan was involuntarily terminated on or after 12/31/98. *If you had ESRD but no longer need regular dialysis or have had a successful kidney transplant,* **please attach a note or records from your doctor** stating this.
2. Do you or your spouse work? ..... ☐ Yes ☐ No
3. Are you enrolled in your State Medicaid program? ..... ☐ Yes ☐ No
   If ***"Yes,"*** please provide your Medicaid number. _____
4. Are you a resident in a long-term care facility, such as a nursing home? ..... ☐ Yes ☐ No
   If ***"Yes,"*** please provide the following information:

   Name of Facility _____ Facility Phone no. (____)_____ Admission Date _____

   Address of Facility _____
   Street address *City* *State* *Zip code*

Please complete question 5 only if you are applying for a plan with Medicare Prescription Drug coverage:

5. In addition to Anthem Medicare Preferred, 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. Name _____ ID no. _____ Group no. _____

Section 6: Important — 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 7: Please provide your Enrollment Period information.

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, or the MA Open Enrollment Period (MA-OEP) from January 1 to March 31 of each year — unless you are newly eligible for Medicare (in your Initial Enrollment Period, or ICEP) or you are eligible for a Special Enrollment Period (SEP). Please read the following statements and check all that apply to you. We will contact you for additional information.

- ☐ 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 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 moved outside of the service area for my current plan. (SEP) Date of move: ___/___/_____
  Mo. Day Year
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I receive extra help from Medicare to pay for Medicare prescription drug coverage. (SEP)
- ☐ I am no longer eligible for extra help from Medicare to pay for my Medicare prescription drug coverage. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE) program. (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)
- ☐ I recently returned to the United States after living permanently outside of the U.S. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (at least as good as Medicare's). (SEP)
- ☐ I'm enrolled in the Original Medicare Plan.

If none of the statements applies to you or if you are not sure, please contact us to see if you are eligible to enroll.

Section 8: Application Agreement *Important:* Read this information before signing in Section 9 below.

By completing this enrollment application, I agree to the following: The plan I am applying for is a Medicare Advantage plan and I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time. I am responsible for informing Anthem Blue Cross and Blue Shield (Anthem) of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under special circumstances, by sending a request to Anthem or by calling 1-800-MEDICARE. TTY/TDD users should call 1-877-486-2048. These numbers are available 24 hours a day, 7 days a week.

The plan I am applying for 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 Medicare Advantage 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, beginning on the date my coverage begins, services obtained out of network will generally result in higher out-of-pocket costs — except for emergency services, urgently needed services or out-of-area dialysis services. 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 files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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 information, 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 9: Signatures

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. 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.

Authorized signature*	Today's Date

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

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

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

Office Use : Name/Code Number of staff member (if he/she assisted in enrollment):

Inside rep.: _____/_____

Field rep.: _____/_____

Plan ID #:_____ and Effective Date of Coverage_____ ***or*** ☐ Not Eligible

Agent/Broker Use :

Date received from applicant: _____

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

Please check the code to use for commission payment:

☒ Agent/Broker's Code No.: BCLNGNPVMZ

☐ Agency Code No.: _____

Agent/Broker

Signature _____

Date _____

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.: ( ) 818-654-454

Fax No.: ( ) 818-776-9865

E-Mail Address: oleg@askoleg.com