# 3 Easy Steps… Enrolling…to Anthem Blue MedicareRX

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.**
Be sure you follow the instructions on the application carefully.
1. Print all pages of the application including instructions.
2. Complete all questions.
If you have any questions, or you are not sure how to answer a question, simply contact us:
Tel. **(818) 987-5000 fax: (818) 776-9865**

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** -

1. I would like to deduct from my Social Security Administration benefit check.
2. I would like to deduct from my checking account(complete "Optional Monthly Checking Account Deduction Authorization" form to page 4).
3. I would like to receive a premium bill and mail my check to Freedom Blue each month.

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

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

**Or Fax the compete : 1-818-776-9865** (fastest way)
**When you fax the application to us make sure you include void check if you select "deduct from my checking account".**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact us:**
**Oleg Skurskiy**
Authorized Independent Agent
Tel.: 1-818-987-5000
Fax: 1-818-776-9865
oleg@askoleg.com

**Thank you for choosing...**
Anthem Blue MedicareRx℠

# Blue MedicareRx℠
# Medicare Prescription Drug Plan Individual Enrollment Form

Anthem

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

| Last name | First name | MI | ☐ Mr. ☐ Mrs. ☐ Ms. |
|---|---|---|---|
| | | | |

| Permanent residence street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Social Security number (optional) | Date of birth | Sex | Home phone number |
|---|---|---|---|
| | _____/_____/_____ | ☐ Male ☐ Female | ( ) |

Mailing address (only if different from your permanent residence address)

| Street/P.O. Box | City | State | ZIP code |
|---|---|---|---|
| | | | |

**Step 2: Please select a Benefit Plan – Choose only one.**

| ☐ Blue MedicareRx | ☐ Blue MedicareRx Plus | ☐ Blue MedicareRx Premier |
|---|---|---|
| Monthly Premium $21.05 | Monthly Premium $29.20 | Monthly Premium $35.98 |

**Step 3: Please provide your Medicare Insurance information.**

Please take out your Medicare Card to complete this section.

- Please fill in these blanks 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 Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.


Name _____

Medicare Claim Number Sex ____

__ __ __ - __ __ - __ __ __ __

Is Entitled To Effective Date

**HOSPITAL (Part A)** _____

**MEDICAL (Part B)** _____

**Step 4: Please read this important information.**

**If you are a member of a Medicare Advantage Plan (like an HMO or PPO),** you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Blue MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

**If you currently have health coverage from an employer or union, joining Blue MedicareRx could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Blue MedicareRx 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.

**Step 5: Please select your plan premium payment option.**

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail or automatic withdrawal from your bank account. If you choose to make monthly payment by automatic withdrawal from your bank account, please complete the enclosed Automatic Payment Option form. Generally you must stay with the option you choose for the rest of the year.

**Note:** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the difference, if there is any, deducted from your monthly check.

**Would you like the premium for this prescription drug plan deducted from your SSA monthly benefit check?** ☐ **Yes** ☐ **No**

**Step 6: Please answer the following questions to help Medicare coordinate your benefits.**

**1.** Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Blue MedicareRx? ☐ **Yes** ☐ **No** *If yes, please list your other coverage and your identification (ID) number(s) for this coverage.*

Name of other coverage _____

ID number _____ Group number _____

**2.** 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 Institution _____

Address of Institution _____

Phone number of Institution ( _____ ) _____

**Step 7: Please read and sign below.**

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

Blue MedicareRx is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Blue MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue MedicareRx or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Blue MedicareRx serves a specific service area. If I move out of the area that Blue MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

***Release of Information:***

By joining this Medicare prescription drug plan, I acknowledge that Blue MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that **1)** this person is authorized under State law to complete this enrollment, and **2)** documentation of this authority is available upon request by Blue MedicareRx or by Medicare.

**Your Signature*** _____ **Today's Date** _____

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

Name _____ Address _____

Phone number _____ Relationship to Enrollee _____

*If anyone helped the individual fill out this form, he or she must sign below.*

**Signature** _____ **Relationship** _____ **Date** _____

***Medicare Prescription Drug Plan Use Only:*** Plan ID # _____

Effective Date of Coverage _____ IEP _____ AEP _____ SEP (type) _____

Agent Signature** _____ Agent Number **BCLNGNPVMZ**

Broker Signature** _____ Code Number _____

**I have assisted the applicant in filling out this application. ☐ **Yes** ☐ **No**

Anthem

# Automatic Payment Option

## Keeping Life Simple

**Looking for a way to make life easier? We can help!**

With the Automatic Payment Option, you can have your monthly premium withdrawn from your bank account on the due date of your bill.

Automatic payment helps ensure the uninterrupted protection you count on. By signing up for this FREE service today, you get the peace of mind that comes with knowing your monthly premium is paid on time, every time. You have less paperwork, fewer checks to write, and less postage to pay.

**This form is valid for 60 days. If automatic bank draft from your account is not established by that time, a new authorization form will be required.**

### No late or missed payments

No more worries about missing your payments and having a lapse in coverage.

### Reduced paperwork

One simple form ends monthly checks, postage costs, and possible mail delays. Your bank statement will reflect the payment each month.

**Notice:** With this option, no billing statements will be sent to you.

### Quick and easy sign-up

Complete the Automatic Payment Option Authorization Form on the reverse side of this notice and mail it to the appropriate location (indicated at the top of the form). You will receive a confirmation letter indicating the date on which your automatic payment service will begin.

*(PLEASE NOTE: You must include the first month's premium with your application in order to allow time to set up the automatic withdrawal from your bank.)*

# Automatic Payment Option Authorization Form

I hereby authorize **Anthem Blue Cross and Blue Shield**, to initiate debit entries of premiums or any other related payments on my behalf and credit entries to my account indicated below, and the financial institution named below to debit/credit the same to such account.

| | | | |
|---|---|---|---|
| Enrollment type ☐ New ☐ Revised | Requested effective date | | |
| **Financial Institution Information** | | | |
| Bank Account type ☐ Checking | | | |
| Financial Institution name | | | |
| Address | City | State | ZIP code |
| Bank Account no. | Bank ABA no. | | |
| **PLEASE ATTACH A BLANK, VOIDED CHECK FOR CHECKING ACCOUNT DEDUCTION.** | | | |
| **Customer Information** | | | |
| Last name | First name | | MI |
| **Anthem Blue Cross and Blue Shield** identification no. | | | |
| Home Address | City | State | ZIP code |
| Contact person name | Phone no. | | |

This authorization is to remain in full force and effect until **Anthem Blue Cross and Blue Shield** and the above-named Financial Institution have received written notification simultaneously from me of its termination in such manner as **Anthem Blue Cross and Blue Shield** and the above-named Financial Institution have a reasonable opportunity to act on it. **This form is valid for 60 days. If automatic draft from your bank is not established by that time, a new authorization form will be required.**

| Printed name | Authorized Signature on this account | Date |
|---|---|---|
| | | |



11758ANT 10/05


Anthem Insurance Companies, Inc (AICI) is the legal entity under contract with the Centers for Medicare and Medicaid Services (CMS) authorized to offer the applicable Medicare Prescription Drug (Part D) plans and services in this region. AICI is the legal entity licensed under applicable state law or under a federal waiver program that is authorized to offer these Part D plans. AICI has partnered with its affiliated local companies to provide various administrative and management services for these Part D plan(s).



11712CO 10/05