

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:
Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction or paper bill).

Step 3

SEND THE COMPLETED APPLICATION TO:

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...



Medicare Supplement Application

IMPORTANT — PLEASE READ CAREFULLY

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid or may not need a Medicare supplement policy.
- The benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).
- If the application is approved, the effective date of enrollment will be listed on the subscriber's coverage notice. Memberships are effective on the 1st day of the month following approval by Anthem.
- No person other than the applicant shall alter any written application for any policy without the applicant's written consent. The exception is that the insurer may make insertions, for administrative purposes only, in such manner as to indicate clearly that such insertions are not ascribed to the applicant.
- In no event shall the Company incur any liability before an application is approved or with respect to an application that has been declined. No coverage shall exist under the agreement, or which the application is made, until approved by Anthem.

SECTION I

Medicare Supplement Plan Application

Broker Name: Oleg Skurskiy

Colorado Nevada

Broker Number: BCLNGNPVMZ

BROKER SIGNATURE _____ DATE _____

X

Broker E-mail Address: Oleg@askoleg.com

Broker Phone Number: 818-987-5000 Broker Fax Number: 818-776-9865

PLAN SELECTION Plan A Plan B Plan F Plan I Plan J

RX Consumer Card Program Yes, I want to participate in the program
(at no extra cost) No, I do not want to participate in the program

MONTHLY PAYMENT METHOD ELECTRONIC FUNDS TRANSFER (EFT) (PREFERRED METHOD), OR PAPER BILL

If choosing Electronic Funds Transfer, please complete the Monthly Bank Draft / EFT Authorization and attach a voided check.

No Application will be processed without the initial month's premium being received.

Initial month payment method: Check Money Order Credit Card Debit Card

Credit / debit card accepted for initial payment only - if paying with a credit / debit card, you must fill out the bottom section of Form No. 98644.

SECTION II FORM MUST BE FILLED OUT IN BLACK BALLPOINT – PLEASE PRINT CLEARLY

NAME (Last, First, Middle Initial)			<input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE Month: Day: Year	HEIGHT	WEIGHT
PHYSICAL STREET ADDRESS			HOME TELEPHONE ()	WORK TELEPHONE ()		
CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER			

If you are enrolled, in or have had, a medical insurance plan in the past 12 months, please complete the following:

NAME OF POLICYHOLDER		SUBSCRIBER NUMBER	GROUP NUMBER
NAME OF INSURER*	CITY, STATE, ZIP CODE OF INSURER		
ISSUE DATE	DATE POLICY PAID THROUGH	POLICY TYPE (i.e., Major Medical, HMO, Hospital only, Specific Disease)	

***Please supply certificate of creditable coverage.**

MEDICARE INFORMATION – You must have Medicare Part A and Medicare Part B coverage and be 65 years of age and older to enroll. Please give your Medicare information as shown on your red, white and blue card.

Health Insurance Claim Number	Medicare Hospital (Part A) Effective Date	Medicare Medical (Part B) Effective Date
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SECTION III REQUESTED EFFECTIVE DATE

Requested effective date: 1st of _____ (Month)
All monthly premium will be due on the first of each month. If you are approved for an effective date other than the first of the month, your premium will be prorated for that first month. You must submit your application at least three (3) weeks prior to the desired effective date. We must receive the completed application by the 10th of the prior month in order for the application to be approved for the 1st of the following month.

SECTION IV

HEALTH STATEMENT

Have you consulted, had diagnostic or other medical tests, or been treated by any doctor, health care professional, hospital, hospital emergency room, or clinic within the last five (5) years for any of the following conditions, diseases or disorders?

(All questions must be answered.)

CONDITION/DISEASE/DISORDER	YES	NO	CONDITION/DISEASE/DISORDER	YES	NO
Alcohol or Drug Abuse			Male/Female Genital Disorders including Hysterectomy, Sterilization and Infertility Procedures		
Back, Spine or Bone Diseases, or Arthritis					
Brain or Nervous System Disorder or Migraine Headaches			Nervous and Mental Disorders including Anxiety, Depression, Anorexia or Attention Deficit Disorder		
Cancer or Malignant Conditions			Paralysis, Epilepsy, Stroke, Parkinson's Disease, Convulsions or Fainting		
Cardiovascular Disorders, Chest Pain, Hypertension, Heart Disease or High Cholesterol			Sinusitis, Tonsillitis, or Adenoid Disorders		
Cataract or other Eye Disorders			Stomach or Colon Disorders including Colitis, Diverticulosis, Diverticulitis, or Ulcers		
Cirrhosis, Hepatitis or other Liver Disorders					
Diabetes or other Endocrine (Glandular) Disorders			Have you received medical advice, been treated or diagnosed for any other condition(s), disease(s) or disorder(s) not listed above? Must check "Yes" or "No." If "Yes," specify and complete the detailed information below.		
Emphysema, Bronchitis, Asthma, or other Lung Disorders					
Gallbladder Disorders					
Hemorrhoids or other Rectal Disorders			Are you currently taking any prescription drugs or medicines — including narcotics, barbiturates or amphetamines?		
Hernias					
Kidney Disorders: Blood, Pus, Albumin, Sugar or Casts in Urine					

Please provide information for any "Yes" answer you checked above. Include name, nature of illness or condition/disease/disorder, duration of treatment and outcome, if applicable. Show specific names of medications and quantity taken, including milligrams and times per day. **ATTACH SEPARATE SHEET IF NECESSARY. (THIS SECTION MUST BE COMPLETED).**

DATE STARTED (Month, Day, Year)	ATTENDING PHYSICIAN, HOSPITAL OR CLINIC NAME AND COMPLETE ADDRESS	NAME OF CONDITION(S) ILLNESS(ES) TREATED	TREATMENT RENDERED SUCH AS CHECK-UP, X-RAY, LAB AND SURGICAL PROCEDURES, ETC. AND OUTCOME		
	NAME		MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN			
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN			
	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN			
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN			

Provide information for the questions listed below, for you and each family member to be covered. **If additional space is required, attach a separate sheet.**

	YES	NO
Are you planning any hospitalization, medical or surgical treatment, or has any treatment been recommended? If "Yes," give details:		
Have you, at any time in the past been declined health, disability or life insurance or had your health, disability or life insurance cancelled or rescinded? If "Yes" give reason(s):		
Have you tested positive for the AIDS virus or are you currently being treated for AIDS?		

AGREEMENT

I certify that the information contained in this application is true and correct to the best of my knowledge and belief. I authorize the release of Medicare claims information to Anthem Blue Cross and Blue Shield to allow payment of any supplemental benefit. I understand that this application shall become part of the contract between Anthem Blue Cross and Blue Shield and myself and that any misstatements contained herein shall void the Membership Certificate.

Pre-existing condition exclusions shall not apply during the initial six-month open enrollment period for individuals age 65 and older when they first enroll in Medicare Part B who had six months of continuous creditable coverage.

If an applicant qualifies and submits an application during the six month open enrollment period and as of the date of application, has had a continuous period of creditable coverage of at least six months with no gap in coverage greater than 63 days, the issuer shall not exclude benefits based on a pre-existing condition.

If the applicant qualifies and submits an application during the six month open enrollment period and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any pre-existing condition exclusion by the aggregate period of creditable coverage applicable to the applicant as of the enrollment date.

The following waiting period for pre-existing conditions applies to Members who are 65 years of age and older and are applying more than 6 months after their effective date under Medicare Part B, but who have had no prior Medical Insurance Plan immediately preceding enrollment under this coverage. Surgical, medical or other health care services provided within the first 6 months after the effective date of coverage are not covered if such services are related to any disease, disorder, condition or procedure for which medical advice was given or treatment was recommended by, or received from, a physician within 6 months before the effective date of coverage. I further understand that my coverage will not pay for services during this time period although such services may be covered by Medicare Part A or Part B.

I acknowledge that I have received the Outline of Coverage.

If the application is approved, the effective date of enrollment will be the 1st of the month following the date of approval. I understand that if my application is not approved, Anthem Blue Cross and Blue Shield will disclose, in writing, the reason(s) for non-acceptance. Once you become effective, we must receive a 30-day advance written notification to cancel your coverage.

FOR COLORADO APPLICANTS ONLY: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I authorize any provider of medical services or supplies to furnish and release to Anthem Blue Cross and Blue Shield all medical records which it may require for the purpose of evaluating the information provided in this application. **If there is a charge for these records, I understand that I am fully responsible for payment. A photographic copy of this authorization shall be as valid as the original.**

I hereby authorize that:

1. at the request of Anthem, any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem about health-related services and supplies provided to me, persons covered under my health coverage, or persons to be covered under my health coverage. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;
2. the Medical Review and Underwriting departments or agents of Anthem upon receiving this information may use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement request, or a request or change in policy benefits;
3. unless I revoke this authorization, this authorization is valid for 24 months from the date I signed it and;
4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE, IF APPLICABLE on behalf of himself/herself and all other minor Person(s) X	DATE
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If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application.

This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization, any information received by Anthem Blue Cross and Blue Shield pursuant to this authorization is subject to restrictions on

PLEASE INDICATE IF YOU ARE SIGNING FOR THE APPLICANT <input type="checkbox"/> Legal Representative <input type="checkbox"/> Trustee (If trustee or legal representative, please supply legal documentation)	YOUR SOCIAL SECURITY NUMBER
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Incomplete Applications Will Be Returned. Have You . . .
 Completed Health Statement? Signed and Dated Application?
****ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM** OR FILL OUT THE CREDIT CARD AUTHORIZATION (FORM NO. 98644) AND INCLUDE IT WITH THIS APPLICATION.**

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE
Anthem Blue Cross and Blue Shield • P.O. Box 173334 • Denver, CO 80217

According to information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. You have the right to return this policy within thirty days after its delivery and have any premium refunded if, after examination of the policy, you are not satisfied for any reason.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision you should evaluate the need for accident and sickness coverage you have that may duplicate this policy.

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force?
 - a) If so, with which company?
 - b) If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?
2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?
 - a) If so, which which company?
 - b) What kind of policy?
3. Are you covered for medical assistance through the state Medicaid program?
 - a) As a Specified Low Income Medicare Beneficiary(SLMB)?
 - b) As a Qualified Medicare Beneficiary (QMB)?
 - c) For other Medicare medical benefits?
4. Producers shall list any other health insurance policies they have sold to the applicant.
 - 1) List policies sold which are still in force.
 - 2) List policies sold in the past five (5) years which are no longer in force

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Moved out of HMO Service area _____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Broker*
Print Broker's Name X Oleg Skurskiy
Print Broker's Address
*Signature of broker required for direct response sales

Monthly Bank Draft / Electronic Funds Transfer Authorization (Optional)

You can choose to have Anthem automatically deduct your premium and any state-mandated fees if applicable ("payment") from your checking account each month. Once your application is approved, your Electronic Funds Transfer Account (EFT) will be set up within 30 days from your effective date. Until the service is effective, Anthem will mail your bill for your monthly payment. To set up EFT, simply complete this section and be sure to include your first month's payment, or fill out the Initial Payment Only Credit Card Payment section below, when you return your completed application.

Bank Name	Name(s) on Bank Account
Your Bank's Routing Number	Your Bank's Account Number

I authorize Anthem Blue Cross and Blue Shield (listed on bank statement as Rocky Mountain Hospital and Medical Service, Inc.) to deduct my monthly payment due each month. The amount deducted each month will be a consistent amount unless there is a rate increase or change in state-mandated fees, where applicable. If there is an outstanding balance forward due, plus my regular payment due, I will be asked to provide authorization to allow for the entire amount to be deducted. This agreement remains in effect until Anthem Blue Cross and Blue Shield receives a 30-day advance written notice from the Bank Account holder or subscriber. In the event the Bank does not pay my payment for any reason, I understand that I am responsible for such payment. Failure to make full payments when due may result in termination of my coverage.

Signature (Exactly as it appears on bank records)	Date:
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INTERNAL USE ONLY

AUTO ID#	SUBSCRIBER #	EFFECTIVE DATE
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Initial Payment Only Credit Card/Debit Card Premium Payment (Optional)

You may choose to make your **initial** premium payment by check, money order or credit card/debit card. Credit card/debit card payment is available for your first premium payment only. **All subsequent payments will be made through monthly bills.**

If choosing to pay by credit card/debit card, you must complete **all** of the following information: Credit Card Debit Card
 VISA MasterCard

Card# _____

Expiration Date: (mm/yyyy) _____ \$ _____
 Maximum Premium Amount Authorized

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any difference in premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholders name (If different than applicant. Please Print)
Cardholder Signature:	Date:

INTERNAL USE ONLY: DO NOT WRITE BELOW THIS LINE

IPAD auto ID#	Subscriber #
Date Processed:	Processed by: