

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



### Step 5: 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. If Medicare pays only a portion of this premium, we will bill you 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.*)

- 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.*) 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: _____ ( <i>This is the first 9 digits printed on the lower left corner of your check.</i> )		
  - 3)  I authorize the bank above to allow this deduction of my monthly premium from the account above.
- Deduct my premium 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 up to the point withholding begins.*)

### Step 6: Attestation of Eligibility for an Enrollment Period.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Open Enrollment Period (AEP) from November 15 to December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period – you may be newly eligible for Medicare (in your Initial Enrollment Period, or IEP), or you may be eligible for a Special Enrollment Period (SEP).

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.

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li><input type="checkbox"/> I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)</li><li><input type="checkbox"/> I am newly eligible for Medicare. (IEP)<br/>Eligibility Date: ____ / ____ / ____<br/><small>Mo. Day Year</small></li><li><input type="checkbox"/> I recently moved and this plan is a new option for me.</li><li><input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)</li><li><input type="checkbox"/> I live in a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)</li><li><input type="checkbox"/> I recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)</li><li><input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). (SEP)</li><li><input type="checkbox"/> I recently moved outside of the service area of my current Medicare prescription drug plan. (SEP)<br/>Date of move: ____ / ____ / ____<br/><small>Mo. Day Year</small></li><li><input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. (SEP)</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. (SEP)</li><li><input type="checkbox"/> I receive extra help to pay for Medicare prescription drug coverage. (SEP)</li><li><input type="checkbox"/> I am no longer eligible for extra help to pay for my Medicare prescription drug coverage. (SEP)</li><li><input type="checkbox"/> I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP)</li><li><input type="checkbox"/> I am involuntarily losing coverage I had from an employer or union. (SEP) <i>Attach copy of coverage termination letter.</i></li><li><input type="checkbox"/> I am voluntarily leaving coverage I had from an employer or union. (SEP) <i>Attach copy of coverage termination letter.</i></li><li><input type="checkbox"/> I am eligible to disenroll from my Medicare Advantage plan and enroll in a Part D plan during an MA Open Enrollment Period or during a trial period. (SEP) Provide beginning and end dates of eligibility period:<br/>_____ / _____</li><li><input type="checkbox"/> None of these statements applies to me.*</li></ul> |
|--|--|

\* 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 \_\_\_\_

**Step 7: Please Read This Important Information.**

**If you are a member of a Medicare Advantage Plan (like an HMO or PPO),** you may already have Part D prescription drug coverage as part of your Medicare Advantage plan. If so, by joining MedicareRx Rewards, 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 MedicareRx Rewards could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining MedicareRx Rewards 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 8: 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.

**Step 9: Application Agreement. Important: Read this information before signing in Step 10.**

**By completing this enrollment application, I agree to the following:** The plan I am applying for is a Medicare Part D drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare. Therefore, I will need to keep my Medicare coverage. I am responsible for informing UniCare Life and Health Insurance Company (UniCare) 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. If I am currently in a Medicare prescription drug plan, my enrollment in this plan will end my enrollment in my current plan. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for certain special circumstances.

This 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 UniCare so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access MedicareRx Rewards benefits, except under limited, non-routine circumstances when I cannot reasonably use MedicareRx Rewards network pharmacies. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. When I receive the Evidence of Coverage document from UniCare, I will read it so I know the rules I must follow in order to receive coverage in this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty, in addition to my premium for Medicare prescription drug coverage, in the future.

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.

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with UniCare, he/she may be compensated based on my enrollment in MedicareRx Rewards. 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 prescription drug plan, I acknowledge that UniCare 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, 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.

**Go to Step 10 on next page.**

**Step 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 UniCare 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

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**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: \_\_\_\_\_ App. Rec'd: \_\_\_\_/\_\_\_\_/\_\_\_\_ Coverage Effective: \_\_\_\_/\_\_\_\_/\_\_\_\_ **or**  Not Eligible

**External Agents/Brokers Only:***Please complete all lines below.*

Date received from applicant: \_\_\_\_\_

Agent/Broker's Printed Name: **OLEG SKURSKIY**I helped the applicant fill out this application:  Yes  No

Agency Name: \_\_\_\_\_

*Please check the ID No. to use for commission payment:*
 Agent/  
 Broker's Tax ID No.: **BCLNGNPVMZ**
Address **18375 Ventura Blvd. # 226**
 Agency Tax ID No.: **BCLNGNPVMZ**

 \_\_\_\_\_  
Street address  
**TARZANA, CA 91356**
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_
**External Agent/Broker's**

Signature \_\_\_\_\_

Phone No.: ( ) **818-654-4548**

Date \_\_\_\_\_

Fax No.: ( ) **818-776-9865**E-Mail Address: **OLEG@ASKOLEG.COM**

UniCare Life and Health Insurance Company (UniCare) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. UniCare is the state-licensed, risk-bearing entity offering these plans. UniCare has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs available in this region.

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