3 Easy Steps… Enrolling…to Freedom Blue PPO SM

Just Follow These 3 Easy Steps… 2006/2007 year.

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)654-4548 fax: (818)776-9865**

Step 2

SELECT THE TYPE OF BILLING YOU WANT

Step 3

SEND THE COMPLETED APPLICATION TO:

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

Or Send the application By Fax 818-776-9865

Do not send any money or check to us.

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.: 1-818-654-4548
Fax: 1-818-776-9865
Email: oleg@askoleg.com web site: www.freedomPPO.com

Thank you for choosing...

Thank you for your interest in Freedom Blue PPO.
Below are some tips to help you complete this enrollment form.

HOW TO APPLY FOR FREEDOM BLUE PPO

You are required to answer all of the questions in the following sections of the enrollment form.

Section 1: Applicant Information

Please fill out this form carefully.
We will need your complete Medicare information in order to process your application.

- ✔ Have your Medicare card ready. The Medicare information you provide should match exactly how it appears on your Medicare card. You also have the option of attaching a copy of your Medicare card or your letter of verification from the Social Security Administration or Railroad Retirement Board.
- ✔ Print in ink.
- ✔ Sign and date the enrollment form.

Note: Each person must complete a separate enrollment form.

You must be entitled to Part A of Medicare and must continue to pay your Part B premium to remain eligible as a member of Freedom Blue. Eligibility for Medicare Parts A and B will be verified prior to enrollment. We cannot consider this enrollment form complete until we have obtained your most current Medicare information.

Select your method of payment.
You have a choice of three convenient payment options:

- Your payment can be deducted directly from your Social Security Administration benefit check.
- Your payment can be deducted directly from your monthly checking account.
- You can receive a premium bill and mail your check to Freedom Blue each month.

Section 2: Health Information

Check the appropriate boxes in this section and provide additional information, if necessary.

Section 3: Lock-In Agreement

Read this section completely.

Section 4: Please read carefully - Signature is required

Sign and date the enrollment form. By signing this enrollment form, you acknowledge that you have read and understand the requirements.

If you are unable to sign this application, a court-appointed legal guardian or person having General Durable Power of Attorney (GDPA) must sign this application.

After you have completed the enrollment form, please return the form to your agent o

OLEG SKURSKIY
18375 VENTURA BLVD # 226 QUESTIONS? TEL: 818-654-4548
TARZANA, CA 91356 SEND BY FAX : 818-776-9865

White - Company Copy **Yellow** - Agent Copy **Pink** - Customer Copy

Freedom Blue PPO℠ Enrollment Form

BC Life & Health Insurance Company

Please fill in these blanks so they match your Medicare card

NAME ____

MEDICARE CLAIM NUMBER (including alpha letter) ______________________ SEX __________

IS ENTITLED TO MEDICARE PART A AND PART B

EFFECTIVE DATE (Month / Day / Year)

PART A HOSPITAL INSURANCE ____/____/____

PART B MEDICAL INSURANCE ____/____/____

Section 1 – Applicant Information

Application for Freedom Blue PPO (select one): Plan I ☐ Plan II ☐			Social Security Number (optional)	
Permanent Residence Address, Apt. # (required)				
City			State	Zip
P.O. Box (if applicable)	City	County	State	Zip
Home Telephone Number with Area Code ( )			Date of Birth: (Month / Day / Year)	

Note: If you are currently enrolled in a Medicare Advantage or Prescription Drug Plan, Freedom Blue will automatically cancel your membership in your current Medicare Advantage plan.
You cannot be a member of two Medicare Advantage plans at the same time.

If you are enrolling in a plan with a monthly premium, how would you like to pay future plan premiums?
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. However, because you might be responsible for paying a portion of your plan's monthly premium, you must choose one of the following payment options.

Please choose one of the following payment options:

☐ I would like to have my premium deducted from my Social Security Administration benefit check.

☐ I would like to have my premium deducted from my checking account each month.
Bank name: ______________________________
Bank Routing Number: ____________________ (Your routing number is the first nine digits printed on the lower left corner of your check)
Your Checking Account Number: ______________________________

☐ I would like to receive a premium bill and mail my check to Freedom Blue each month.

Section 2 – Health Information

A. *Do you have End-Stage Renal Disease (ESRD) or receive routine kidney dialysis treatment?* Yes ☐ No ☐
If you have ESRD or have not yet had a successful kidney transplant, you cannot enroll in Freedom Blue unless you are already enrolled as a member of any BC Life & Health Plan or if you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing that you don't need dialysis or have had a successful kidney transplant.

B. Do you or your spouse work? Yes ☐ No ☐
If no, you do not need to complete the Working Aged Survey (Section 5) on page 4.

Section 2 – Health Information Continued

Your answers to the following health information questions will not affect your eligibility to enroll in Freedom Blue.

C. *Are you currently eligible for Medi-Cal?* Yes ☐ No ☐
(California state assistance through the Department of Health Services)
If yes: Medi-Cal number: ______________________________

D. *Are you currently a resident in a Medicare certified institution?* Yes ☐ No ☐
(such as a skilled nursing facility, rehabilitation hospital, etc.)
If yes: Name ________________ Address ______________________ City __________ State _____ Zip ______
Institutition Phone # __________________Date of Admission into Institutition__________________________

E. 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 Freedom Blue? Yes ☐ No ☐
If yes: Please list your other coverage and your identification (ID) number(s) for this coverage.
Name of other coverage______________________________ID#______________ Group #_________________

F. What is the name of your current health plan?____

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Freedom Blue could affect your employer or union health benefits or may change how your current coverage works.
Read the communications your employer or union sends you. If you have questions, visit their web site 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 may be able to help.

Section 3 – Lock-In Agreement and Requirements

I understand that all plan benefits, conditions, limitations and exclusions of coverage are detailed in the Freedom Blue Evidence of Coverage, which is given to me when I become a member.

Section 4 – Please Read and Sign Below

I understand that the effective date of coverage is when I can begin using Freedom Blue services, and that BC Life & Health will send me written notification of the effective date of my enrollment in Freedom Blue.
I understand that I should not cancel or drop any supplemental insurance I currently have until I receive written notice of my actual effective date from BC Life & Health.
I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable.
I understand that by enrolling in Freedom Blue, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage plan of which I am currently a member. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
I understand that it is my responsibility to inform BC Life & Health prior to a permanent move out of the Freedom Blue service area or leaving the Freedom Blue service area for a temporary move of more than six months. My absence, under these two conditions means that BC Life & Health may take action to disenroll me from Freedom Blue and return me to traditional Medicare for medical coverage.
I understand that enrollment in this plan is generally for the entire year. I may disenroll from Freedom Blue only at certain times of the year, or under certain circumstances, by sending a written request to Freedom Blue Member Services, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048).
I understand that I must continue to receive all my health care from Freedom Blue providers until BC Life & Health informs me of the effective date of disenrollment.

Section 4 – Please Read and Sign Below Continued

I understand that as a member of Freedom Blue, I have the right to ask about the plan's decision about payment or services if I disagree. Once I am a member of Freedom Blue, I have the right to appeal plan decisions about payment or services if I disagree.

I further understand and acknowledge the selling agent has no authority to promise me coverage or to modify BC Life & Health underwriting policy or terms of any BC Life & Health coverage.

I acknowledge that I have read and understand the Freedom Blue outpatient prescription drug benefit as described in the Freedom Blue Summary of Benefits, a copy of which has been provided to me. I am aware that only those prescription drugs included in Freedom Blue approved Formulary list will be covered under the plan.

I understand that BC Life & Health requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 requires specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

I understand that receipt of money with this enrollment form does not create Freedom Blue coverage. Coverage will come into effect only if this application is approved by BC Life & Health. I, the applicant, acknowledge that I have read and understand the enrollment form and the accompanying marketing materials in their entirety.

If signed by a person authorized to act on my behalf, 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 Freedom Blue or by Medicare.

x____ x______________________________

Applicant's Signature **Date of Signature**

(or signature of Legal Guardian or GDPA)

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

Name:____________________________ Address:____

Phone Number: (_____)_______________Relationship to Enrollee:___________________________________

Please refer to the Freedom Blue Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

AGENT USE ONLY

I have assisted the applicant in filling out this enrollment form: Yes ☐ No ☐

Agent's Signature: ____________________________________

Date:_____________________________________

Print Agent's Name:_____Oleg Skurskiy ___ Agent Number: ___BCLNGNPVMZ _______________

Appointment Set By (TM#)_____________________________ Telephone Number: __818-987-5000_____

Street Address: ______18375 Ventura Blvd # 226 _____ City: ___Tarzana _ State: _CA_ Zip: _91356

BC Life & Health Use Only

Group # ______________________________________ Effective Date of Coverage ______________________

ICEP _________________ AEP ____________________ SEP (type) _________________ OEP ______________

Freedom Blue is an RPPO with a Medicare Advantage contract. Anyone with Medicare may apply. You must be entitled to Part A and be enrolled in Part B, and continue to pay your Medicare Part B premiums. Copayments, restrictions and limitations may apply. Benefits are subject to change annually upon contract renewal with the Medicare program.

CMS WORKING AGED SURVEY

The Centers for Medicare & Medicaid Services (CMS) has requested that we report the current working status of our members. For us to report your working status accurately please complete this survey.
This survey will not affect your Medicare coverage or your membership in our plan.

APPLICANT

Name:____________________________________
Medicare Number:______________________________

1. Are you working or self-employed? Yes ☐ No ☐
   If no, go to SPOUSE section below.

2. Does your employer have 20 or more employees? Yes ☐ No ☐

3. Tell us about your employer.
   Company name: ______________________________
   Address:______________________________
   Phone: ( ) ______________________________

4. Do you have insurance coverage through your employer? Yes ☐ No ☐

5. When did this employer insurance coverage start? Month:____________ Year:____________

6. When did this insurance coverage end? Month:____________ Year:____________

SPOUSE

1. Is your spouse working or self employed? Yes ☐ No ☐
   If no, or you do not have a spouse, end survey. If yes, please complete the following:

2. Spouse's name: ____________________ Social Security Number: ________________

3. Does your spouse's employer have 20 or more employees? Yes ☐ No ☐
   If no, end survey.

4. Does your spouse have insurance coverage through his or her employer? Yes ☐ No ☐

5. When did this employer insurance coverage start? Month: ____________ Year:____________
   Tell us about your insurance.
   Company:______________________________
   Address: ______________________________
   Phone: ( ) ______________________________

6. When did your insurance coverage end? Month:____________ Year:__________ N/A: ________

7. Does your spouse's employer insurance coverage include coverage for you? Yes ☐ No ☐