

3 Easy Steps... Enrolling...to SmartSaver

Just Follow These 3 Easy Steps... 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.FindMedigap.com

Thank you for choosing...





Thank you for your interest in Blue Cross of California SmartSaverSM 4500.
Below are some tips to help you complete this enrollment form.

HOW TO APPLY FOR SMARTSAVERSM 4500

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

Section 1 – Medicare Trustee Information

You must return the completed Mellon Signature Card Form with this Enrollment Form.

This information is required before your Medicare MSA enrollment can be processed.

Section 2: Applicant Information

Please fill out this section completely.

Section 3: Health Information

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

Section 4: Lock-In Agreement

Read this section completely.

Section 5: 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.

Note: SmartSaver 4500 does not include Medicare Part D prescription drug benefits. If you wish to add this coverage through Blue Cross, a separate Part D enrollment form is required. Please submit the Part D enrollment form with your SmartSaver 4500 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 SmartSaver 4500. 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.

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

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

or By fax: 818-776-9865



Blue Cross of California SmartSaverSM 4500 Enrollment Form

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 & B

PLEASE INDICATE YOUR EFFECTIVE DATE (Month / Day / Year)

PART A HOSPITAL INSURANCE _____/_____/_____

PART B MEDICAL INSURANCE _____/_____/_____

Section 1 – Medicare Trustee Information

I understand I am applying for a Medicare MSA Savings Account with Mellon Bank. You must return the completed Mellon Signature Card Form with this Enrollment Form. Signature Card is attached: Yes No

Section 2 – Applicant Information

Permanent Residence Address, Apt. #: (required)			Social Security Number:	
City:		State:		ZIP:
P.O. Box (if applicable)	City:	County:	State:	ZIP:
Home Telephone Number with Area Code: ()		Date of Birth: (Month / Day / Year)		
Providing the following information will allow Blue Cross of California to contact the doctors you see regularly so that we can inform them about the SmartSaver 4500 plan, including the terms and conditions of the plan, and let them know you are applying to be a SmartSaver 4500 member.				
Name of your regular Physician:		Telephone number of your Physician: ()		

E-mail Address (optional): _____

Note: If you are currently enrolled in a Medicare Advantage Plan, enrolling in SmartSaver 4500 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.

Section 3 – Health Information

Your answers to the following questions will affect your eligibility to enroll in Blue Cross SmartSaver 4500.

If you answer yes to questions A - E you may not enroll in Blue Cross SmartSaver 4500.

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 SmartSaver 4500 unless you are already enrolled as a member of any Blue Cross of California 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 anymore or have had a successful kidney transplant, please attach a note or records from your doctor showing that you do not need dialysis or have had a successful kidney transplant.

White - SmartSaver Membership

Yellow - Agent

Pink - Member

Section 3 – Health Information Cont.

- B. Will you reside outside the United States for at least 183 days during each year you are enrolled in SmartSaver 4500? Yes No

To enroll in SmartSaver 4500, you must not have other health coverage as described below.

Please answer each of the following questions:

- C. Are you currently eligible for Medi-Cal? Yes No
(State assistance through the Department of Health Services) If yes: Medi-Cal number: _____
- D. Are you currently receiving hospice benefits? Yes No

Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible.

If you have any other such coverage, you are not eligible to enroll in SmartSaver 4500.

- E. Will you have other health coverage in addition to SmartSaver 4500? Yes No
If yes: Please list your other coverage and your identification (ID) number for this coverage.
Name of other coverage _____ ID# _____ Group # _____

Your answers to the following will not affect your eligibility to enroll in Blue Cross SmartSaver 4500.

- F. Do you or your spouse work? Yes No
If no, you do not need to complete Working Aged Survey (Section 6) on Page 4.
- G. Are you currently a resident in a Medicare-certified institution other than a hospice? Yes No
If yes: Name _____ Address _____ City _____ State _____ Zip _____
Institution Phone # _____ Date of Admission into Institution _____
- H. If converting from another health plan what is the name of the health plan? _____

Section 4 – Lock-In Agreement and Requirements

I understand that plan benefits, conditions, limitations and exclusions of coverage are detailed in the SmartSaver 4500 Evidence of Coverage, which is given to me when I become a member.

Section 5 – Please Read and Sign Below

I understand that the effective date of coverage is when I can begin using SmartSaver 4500 services, and that Blue Cross of California will send me written notification of the effective date of my enrollment in SmartSaver 4500.

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 Blue Cross of California.

I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part A and the Part B premium, if applicable.

I understand that by enrolling in SmartSaver 4500, 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 I am applying for a HDHP (High Deductible Health Plan) and that SmartSaver 4500 will not pay for any of my medical expenses until my high deductible is met.

I understand that my enrollment in SmartSaver 4500 is not complete until the bank account is established. If I have questions regarding the establishment of my MSA bank account, I can contact the plan at the number provided in the bank account enrollment letter in this kit.

I understand that Blue Cross of California may debit my Medical Savings Account for a prorated share of the current year's deposit to be returned to Medicare if I move out of the service area or pass away. Any amounts rolled over from prior years' deposits will not be debited and are mine or my estate's to keep.

Section 5 – Please Read and Sign Below (continued)

I understand that it is my responsibility to inform Blue Cross of California prior to a permanent move out of the SmartSaver service area or leaving the SmartSaver 4500 service area for a temporary move of more than six months. My absence, under these two conditions means that Blue Cross of California may take action to disenroll me from SmartSaver 4500 and return me to traditional Medicare for medical coverage.

I understand that enrollment in this plan is generally for the entire year. I understand that I have the option to cancel my enrollment on or before December 15 if I no longer wish to be enrolled in 2007. Otherwise, I will be locked in for 2007 unless I am eligible to disenroll from SmartSaver 4500 under certain circumstances, by sending a written request to SmartSaver Member Services.

I understand that I must continue to receive all my health care from SmartSaver 4500 providers until Blue Cross of California informs me of the effective date of disenrollment.

I understand that as a member of SmartSaver 4500, I have the right to ask about the plan’s decision about payments or services if I disagree. *Once I am a member of SmartSaver 4500, I have the right to appeal plan decisions about payments or coverage for services I receive, if I disagree.*

I further understand and acknowledge the selling agent has no authority to promise me coverage or to modify Blue Cross of California underwriting policy or terms of any Blue Cross of California coverage.

I understand that receipt of money with this enrollment form does not create SmartSaver 4500 coverage. Coverage will come into effect only if this application is approved by Blue Cross of California and CMS.

I, the applicant, acknowledge that I have read and understand the enrollment form and the accompanying sales and marketing materials in their entirety.

I understand that this Medicare Advantage Medicare MSA Plan is offered by Blue Cross of California under a contract with CMS and CMS’ review and approval of its benefits.

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 SmartSaver or by Medicare.

x _____

Applicant’s 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 Blue Cross of California SmartSaver 4500 Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations and exclusions of coverage.

x _____

Date of Signature

AGENT USE ONLY

I have assisted the applicant in filling out the application: Yes No

Agent’s Signature: _____ Date: _____

Print Agent’s Name: Oleg Skurskiy Agent Number: BCLNGNPVMZ

Sub Agent #: _____ Telephone Number: 818-987-5000

Street Address: 18375 Ventura Blvd. # 226 City: Tarzana State: CA Zip: 91356

Blue Cross of California Use Only

Group #: _____ Effective Date of Coverage: _____

ICEP: _____ AEP: _____ SEP: (type) _____ OEP: _____

Blue Cross of California is an Independent Licensee of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered marks of the Blue Cross Association.



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 if 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