

# Freedom Blue (Regional PPO)

## Individual Enrollment Request Form – 2011



**Be sure to complete the entire enrollment form.** Then, mail the completed form to

**Oleg Skurskiy Authorized Agent**

**18375 Ventura Blvd. # 226**

or by FAX **1-818-776-9865**

**Tarzana , CA 91356**

Please contact Anthem Blue Cross if you need information in another language or format (Braille).

**To enroll in Freedom Blue (Regional PPO), please provide the following information.**

**Please check which plan you want to enroll in:**

Freedom Blue Classic (Regional PPO) \$0 per month

Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth date (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ( )	Alternate phone number ( )
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**Permanent residence street address** (P.O. Box is not allowed.)

City	State	ZIP code
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**Mailing address** (only if different from your permanent residence address)

Street address	City	State	ZIP code
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**E-mail address**

**Please provide your Medicare insurance information.**

Please take out your red, white and blue Medicare card to complete this section.

- Please fill in these blanks so they match your Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE



HEALTH INSURANCE

*SAMPLE ONLY*

Name \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_ Sex \_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is Entitled To \_\_\_\_\_ Effective Date \_\_\_\_\_

**HOSPITAL (Part A)** \_\_\_\_\_

**MEDICAL (Part B)** \_\_\_\_\_

**Please read and answer these important questions:**

1. **Do you have end-stage renal disease (ESRD)?**  Yes  No

If you answered "yes" to this question and you don't need regular dialysis any more or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing that you don't need dialysis or that you have had a successful kidney transplant.

2. **Are you enrolled in your state Medicaid program?**  Yes  No

If "yes," please provide your Medicaid number \_\_\_\_\_

3. **Do you or your spouse work?**  Yes  No

**Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:**

\_\_\_\_\_ Spanish

\_\_\_\_\_ Large print

Please contact Anthem Blue Cross at **1-888-211-9813** if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-241-6894**.

# STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining Freedom Blue (Regional PPO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Freedom Blue (Regional PPO). 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 isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement 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.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get Extra Help paying for Medicare prescription drug coverage.
- I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date) \_\_\_\_\_.
- I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_.
- I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- None of these statements applies to me.\*

\*Please contact Anthem Blue Cross at **1-888-211-9813** (TTY users should call **1-800-241-6894**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week.

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**Applicant Complete:** Name \_\_\_\_\_ and Medicare ID number \_\_\_\_\_

**Please read and sign below.**

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

Freedom Blue (Regional PPO) is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan automatically will end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, November 15 - December 31 of every year), or under certain special circumstances.

Freedom Blue (Regional PPO) serves a specific service area. If I move out of the area that Freedom Blue (Regional PPO) 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 Freedom Blue (Regional PPO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Anthem Blue Cross when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Freedom Blue (Regional PPO) coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Anthem Blue Cross provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Anthem Blue Cross and other services contained in my Freedom Blue (Regional PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ANTHEM BLUE CROSS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Anthem Blue Cross, he/she may be paid based on my enrollment in Freedom Blue (Regional PPO).

By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare Prescription Drug Plan.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Anthem Blue Cross will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Blue Cross will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) 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 Anthem Blue Cross or by Medicare.

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**Applicant Complete:** Name \_\_\_\_\_ and Medicare ID number \_\_\_\_\_

Signature \_\_\_\_\_ Today's date \_\_\_\_\_

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

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Enrollee \_\_\_\_\_

**Applicant: Please do not complete the following sections. For office and agent/broker use only.**

**Internal agents or external agents/brokers, please complete:** Coverage effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

ICEP/IEP  NIPR#  AEP  SEP (type): \_\_\_\_\_  Not eligible

1. Was this an individual face-to-face appointment?  Yes  No (Do not proceed.)

2. If this was an individual face-to-face appointment, how was a scope of appointment (SOA) collected?

Paper

Recorded call (voice vault confirmation number \_\_\_\_\_)

3. Was the SOA signed on the same day as the appointment?  Yes  No (Do not proceed.)

4. If yes, please indicate the best reason below:

Appointment was requested at the end of the month for following month enrollment

Customer walk-in

Request for individual appointment immediately following a seminar sales event

Next day appointment

Other \_\_\_\_\_

**Direct sales reps only:** Complete if you assisted in enrollment.

Print name \_\_\_\_\_

Tax identification number (10 digits) or agent code (variable) |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

Signature \_\_\_\_\_ Application received date \_\_\_\_/\_\_\_\_/\_\_\_\_

**External agents/brokers only:** application received \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please complete all lines below.**

I helped the applicant fill out this application  Yes  No

Agent/broker's printed name **OLEG SKURSKIY**

Please check the identification number to use for commission payment:

Agency name \_\_\_\_\_

**18375 Ventura Blvd. # 226**

Agent/broker's tax identification number

| B | C | L | N | G | N | P | V | M | Z |

Street address \_\_\_\_\_

**Tarzana, CA 91356**

Agency tax identification number

| B | C | L | N | G | N | P | V | M | Z |

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Phone number ( **818 654** ) \_\_\_\_\_ - **4548**

Fax number ( **818 776 9865** ) \_\_\_\_\_ - \_\_\_\_\_

E-mail address **oleg@askoleg.com**

**External agent/broker's**

Signature \_\_\_\_\_

A health plan with a Medicare contract.

Anthem Blue Cross Life and Health Insurance Company (Anthem) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Advantage Regional PPO plan(s) (MAPD-RPPO) noted. Anthem is the risk bearing entity licensed under applicable state law to offer the MAPD-RPPO plan(s) noted. Anthem has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the MAPD-RPPO plan(s) available in this region. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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**Applicant Complete:** Name \_\_\_\_\_ and Medicare ID number \_\_\_\_\_

Y0071\_11\_10481\_R\_005 CMS Approved 08/25/2010

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White - member copy; Yellow - agent copy