To Complete Your Enrollment Form:

1. Be sure to complete all information on the form, sign the form, and date the enrollment form.
2. If you would like the convenience of having your premium deducted from your Social Security check, be sure to check “Yes” in Step 5. If you want to use our other convenient payment options, complete the “Automatic Payment” information included with the enrollment form.

3. Return the form(s) by mail to:

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

Or can fax complete application to Fax: (818) 776-9865

Anthem Blue Cross
Blue Cross MedicareRx^SM

Medicare Prescription Drug Plan Individual Enrollment Form — 2009

Be sure to complete all four pages of the enrollment form and return it to

OLEG SKURSKIY 18375 Ventura Blvd # 226 Tarzana, CA 91356 OR BY FAX 818-776-9865

Step 1: Please provide information about you. (Please print clearly.)

Last Name	First Name	Middle Initial

Permanent residence street address (cannot use P.O. Box)	City	County

State	ZIP Code	Phone No.	Alternate Phone No.	Social Security No. (optional)	Sex	Date of Birth
		( )	( )		☐ M ☐ F	

Mailing/Billing Address (if different from address above)	City	State	ZIP Code

Step 2: Please select a Benefit Plan — Choose only one.

Note to Applicant: For information about the service areas and the premiums of the Medicare Prescription Drug Plans available to you, please refer to the Summary of Benefits enclosed with your enrollment materials.

☐ Blue Cross MedicareRx Value ☐ Blue Cross MedicareRx Plus ☐ Blue Cross MedicareRx Gold

Step 3: Please provide your Medicare Insurance information.

Please take out your Medicare Card to complete this section.

- Please fill in the blanks at right so they match your red, white and blue Medicare card.

-or-

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

Name ____________________

Medicare Claim Number Sex ____

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Is Entitled To: Effective Date:

Hospital (Part A) ____________

Medical (Part B) ____________

Step 4: Please answer the following questions to help Medicare coordinate your benefits.

1. 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 Blue Cross MedicareRx? ☐ **Yes** ☐ **No** *If* ***"Yes,"*** *please list your other coverage and your identification (ID) number(s) for this coverage.*

Name of other coverage ____________________

ID number ____________________ Group number ____________________

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No** *If* ***"Yes,"*** *please provide the following:*

Name of Institution ____________________

Address and phone no. of Institution ____________________ / (_____) ____________

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al numero telefónico que se muestra en el material adjunto. C0003_08_008 07/2007

Office Use Only: Date Stamp

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 checking 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: __________________________ *(This is the first 9 digits printed on the lower left corner of your check.)*
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.

☐ I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)

☐ I am newly eligible for Medicare. (IEP)
Eligibility Date: ___/___/_______
Mo. Day Year

☐ I recently moved and this plan is a new option for me.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)

☐ I live in a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)

☐ I recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). (SEP)

☐ I recently moved outside of the service area of my current Medicare prescription drug plan. (SEP)
Date of move: ___/___/_______
Mo. Day Year

☐ I recently returned to the United States after living permanently outside of the U.S. (SEP)

☐ I belong to a pharmacy assistance program provided by my state. (SEP)

☐ I receive extra help to pay for Medicare prescription drug coverage. (SEP)

☐ I am no longer eligible for extra help to pay for my Medicare prescription drug coverage. (SEP)

☐ I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP)

☐ I am involuntarily losing coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*

☐ I am voluntarily leaving coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*

☐ 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:
______________ /________________

☐ None of these statements applies to me.*

** 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 _______*

 For Applicant to Complete: Name ______________________________ & Medicare ID#______________________

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 Blue Cross MedicareRx, 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 Blue Cross MedicareRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue Cross MedicareRx 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 Anthem Blue Cross (Anthem) 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 Anthem so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access Blue Cross MedicareRx benefits, except under limited, non-routine circumstances when I cannot reasonably use Blue Cross MedicareRx 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 Anthem, 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.

Gold Plan Members Only: By joining the Blue Cross MedicareRx Gold Plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with Anthem, he/she may be compensated based on my enrollment in Blue Cross MedicareRx. 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.

Step 9 continues on next page.

 For Applicant to Complete: Name ______________________________ & Medicare ID#______________________

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that Anthem 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.

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 Anthem 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

SCAFR1516CD 08/08 S5596 C0003_09_029 09/2008

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:

Date received from applicant: ______

I helped the applicant fill out this application: ☐ Yes ☒ No

Please check the ID No. to use for commission payment:

☒ Agent/ Broker's Tax ID No.: BCLNGNPVMZ

☐ Agency Tax ID No.: BCLNGNPVMZ

External Agent/Broker's

Signature ______

Date ______

Please complete all lines below.

Agent/Broker's Printed Name: OLEG SKURSKIY

Agency Name: OLEG SKURSKIY

Address 18375 VENTURA BVLD # 226
Street address

TARZANA CA 91356
City *State* *ZIP code*

Phone No.: ( ) 818-654-4548

Fax No.: ( ) 1-776-776-9865

E-Mail Address: OLEG@ASKOLEG.COM

Anthem Insurance Companies, Inc. (AICI) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. AICI is the state-licensed, risk-bearing entity offering these plans. AICI 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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