

2012 Enrollment

CALIFORNIA ENROLLMENT FORM

**Please print out the form below and mail
your signed completed form to:**

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

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

If you have questions or need assistance with your application, please call 1-818-654-4548

We are licensed only in the states:

California, Colorado, Nevada, Arizona, Texas, Illinois, Ohio, Virginia, Georgia, Connecticut ,
New Hampshire, Oregon

If you are out of the state above, please call 1-800 medicare

Blue Cross MedicareRx (PDP)

Medicare Prescription Drug Plan

Individual Enrollment Form – 2012



Be sure to complete the entire enrollment form. Then, **mail** the completed form to 18375 VENTURA BLVD # 226 or **fax** the completed form to 1-818-776-9865 You can also enroll online at TARZANA, CA 91356 . **Note:** Your agent/broker may provide different instructions.

Please contact Anthem Blue Cross Life and Health Insurance Company if you need information in another language or format (Large Print or Braille).

To enroll in Blue Cross MedicareRx (PDP), please provide the following information:			
Please check which plan you want to enroll in:			
<input type="checkbox"/> Blue Cross MedicareRx Standard (PDP) \$39.30 per month	<input type="checkbox"/> Blue Cross MedicareRx Plus (PDP) \$62.80 per month	<input type="checkbox"/> Blue Cross MedicareRx Gold (PDP) \$107.30 per month	
Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (/ /) (M M / D D / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ()	Alternate phone number ()
Permanent residence street address (P.O. Box is not allowed.)			
City	State	ZIP code	County
Mailing address (only if different from your permanent residence address)			
Street address	City	State	ZIP code
Email address			

Please provide your Medicare insurance information.	
<p>Please take out your red, white and blue Medicare card to complete this section.</p> <ul style="list-style-type: none"> · 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. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	
	<i>SAMPLE ONLY</i>
	Name _____ Medicare Claim Number _____ Sex ____ _____ - _____ - _____
	Is Entitled To _____ Effective Date _____ HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Applicant Complete: Name _____ and Medicare ID number _____

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or electronic funds transfer (EFT) each month. You also can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT** pay Anthem Blue Cross Life and Health Insurance Company the Part D-IRMAA extra amount to Blue Cross MedicareRx (PDP).

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You also can apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please choose one of the options below: (If no option is chosen, you will receive a monthly bill for the amount due.)

Monthly Bill: Send me a bill each month.

Automatic Bank Account Deduction: Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your **first** payment.) Please complete steps 1, 2 and 3 below:

1) Account type: **Checking:** Must enclose a VOIDED check. **Savings:** Must enclose letter from financial institution with account information.

2) Please complete the following information for your account:

Account holder name _____ Account number _____

Bank routing number _____ Bank name _____

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

3) I authorize the bank above to allow this monthly deduction of the amount from the account above.

Automatic Social Security or Railroad Retirement Board (RRB) Deduction: Deduct the amount from my Social Security or Railroad Retirement Board (RRB) benefit check each month. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the date withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

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 your Blue Cross MedicareRx (PDP)? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage _____ ID number for this coverage _____ Group number for this coverage _____

2. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes," please provide the following information:

Name of institution _____

Address (number and street) and phone number of institution _____

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 _____ Chinese

_____ Large Print _____ Braille

Please contact an Anthem Blue Cross Life and Health Insurance Company Customer Service agent at **1-800-928-6201** 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 **1-877-247-1657**.

STOP

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 from your Medicare Advantage plan that will meet your needs. By joining Blue Cross MedicareRx (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. 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 (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross MedicareRx (PDP). 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 prescription drug plan (PDP) only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year. Additionally, there are exceptions – i.e., Initial Enrollment Period (ICEP) and Special Enrollment Periods (SEPs) – that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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. **NOTE: You must select at least one of the options below.**

- I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- I am new to Medicare. (ICEP)
- 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) _____. (SEP)
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)
- I get Extra Help paying for Medicare prescription drug coverage. (SEP)
- I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on (insert date) _____. (SEP)
- I 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) _____. (SEP)
- I recently left a PACE program on (insert date) _____. (SEP)
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____. (SEP)
- I am leaving employer or union coverage on (insert date) _____. (SEP)
- I belong to a pharmacy assistance program provided by my state. (SEP)
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____. (SEP)
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. (SEP)
- None of these statements applies to me.*

*Please contact an Anthem Blue Cross Life and Health Insurance Company licensed insurance agent at **1-866-892-5340** (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.

Please read and sign below.

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

Blue Cross MedicareRx (PDP) is a Medicare 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 Part A or Part B coverage. It is my responsibility to inform Anthem Blue Cross Life and Health Insurance Company 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 Blue Cross MedicareRx (PDP) will end that enrollment. 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 (October 15 – December 7), unless I qualify for certain special circumstances.

Anthem Blue Cross Life and Health Insurance Company serves a specific service area. If I move out of the area that Anthem Blue Cross Life and Health Insurance Company serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Anthem Blue Cross Life and Health Insurance Company network pharmacies. Once I am a member of Blue Cross MedicareRx (PDP), 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 Life and Health Insurance Company when I get it to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Anthem Blue Cross Life and Health Insurance Company, he/she may be paid based on my enrollment in Blue Cross MedicareRx (PDP). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, 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 Anthem Blue Cross Life and Health Insurance Company 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 Life and Health Insurance Company 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 State law 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 from Medicare.

Signature	Today's date
Desired plan effective 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 AEP SEP (type): _____ Not eligible

PLAN ID #: _____ NIPR #: _____

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 the 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 ____/____/____

I helped the applicant fill out this application Yes No

**REQUIRED/MANDATORY: Please fill in BOTH required fields - 'Writing Agent' and 'Agency' with your assigned Code, Tax ID, or Encryption based on your appointed brand, state AND product.*

Writing Agent TIN/Agent Code

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

Agency TIN/Agency Code (NOTE: If you are directly appointed, populate your writing information again.)

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

Please complete all lines below.

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

Agency name **OLEG SKURSKIY**

18375 VENTURA BLVD # 226

Street address

TARZANA, CA 91356

City

State

ZIP code

Phone number (**818**) **654 4548**

Fax number (**818**) **7769865**

Email address **OLEG@ASKOLEG.COM**

External agent/broker's

Signature _____

This plan is a PDP with a Medicare contract. Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. Anthem is the state-licensed, risk-bearing entity offering these plans. Anthem 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. 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.