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 1-818-987-5000

We are licensed only in the states:
California, Colorado, Nevada, Arizona, Texas, Illinois, Ohio, Virginia, Georgia, Connecticut , New Hampshire,

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

Anthem Blue Cross MedicareRx (PDP)

Medicare Prescription Drug Plan

Individual Enrollment Form — 2015

Be sure to complete the entire enrollment form. Then, **mail** the completed form to **P.O. Box 659404, San Antonio, TX 78265-9863** ***or*** **fax** the completed form to **1-877-391-3877**. You can also enroll online at **www.anthem.com/ca/shop.** ***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 Anthem Blue Cross MedicareRx (PDP), please provide the following information.			
Please check which plan you want to enroll in:			
☐ **Anthem Blue Cross MedicareRx Standard (PDP) $36.80 per month**	☐ **Anthem Blue Cross MedicareRx Plus (PDP) $74.70 per month**	☐ **Anthem Blue Cross MedicareRx Gold (PDP) $119.20 per month**	
Last name	**First name**	**MI**	☐ **Mr.** ☐ **Mrs.** ☐**Ms.**
Birthdate (MM/DD/YYYY)	**Sex** ☐ M ☐ 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)			
City	State	ZIP code	
☐ Check here if you are interested in receiving health plan related communications via email in the future. Please provide your email address below, and we will let you know when these become available. **Email address**			

Applicant Complete: Name _____ and Medicare Claim Number _____

White - agent copy; Yellow - member copy

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 or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Claim Number _____ Sex ____

Is Entitled To — Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Anthem Blue Cross Life and Health Insurance Company.

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.

Applicant Complete: Name _____ and Medicare Claim Number _____

☐ **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. (**After Social Security or RRB approves the automatic deduction, it may take two or more months for the deduction to begin.** In most cases, 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 the automatic deduction begins. If Social Security or RRB delays or 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 your current prescription drug coverage be ending? ☐ Yes ☐ No ☐ N/A

Will you continue to have other prescription drug coverage? ☐ Yes ☐ No ☐ N/A

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

Dates Covered: **Start**___ ___ _____ **End**___ ___ _____ Name of other coverage _____

ID # for this coverage _____ Group # 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 contact Anthem Blue Cross Life and Health Insurance Company at 1-800-928-6201 if you need information in an alternate language or format. Our office hours are 8 a.m. to 8 p.m., 7 days a week from October 1, 2014 to February 14, 2015; Monday-Friday, February 15 to September 30, 2015. TTY users should call 711. Phone help is available for most languages and for reading assistance. This plan also provides some documents in these languages and formats:

Spanish, Large Print, Braille, Audio Tape, Voice-Enabled PDFs.

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 Anthem Blue Cross Life and Health Insurance Company 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 Anthem Blue Cross Life and Health Insurance Company could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Anthem Blue Cross Life and Health Insurance Company. 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.

Applicant Complete: Name _____ and Medicare Claim Number _____

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 (IEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Prescription Drug 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. (IEP)

☐ I am turning 65 and not new to Medicare. (IEP2)

☐ 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 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) _____ . (SEP)

☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____ . (SEP)

☐ I recently involuntarily lost my creditable prescription drug coverage (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)

☐ I am making this enrollment request between January 1 and February 14, and I recently ended or plan on ending my enrollment in a Medicare Advantage plan. The date that my Medicare Advantage plan ends/ended on is (insert date) _____ .

☐ Other* _____

*Please contact Anthem Blue Cross Life and Health Insurance Company at **1-800-928-6201** (TTY users should call **711**) to see if you are eligible to enroll.

Applicant Complete: Name _____ and Medicare Claim Number _____

Please read and sign below.

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

Anthem 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 Anthem Blue Cross Life and Health Insurance Company 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 MedicareRx (PDP) 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 Anthem 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 have had a prior break in creditable prescription drug coverage (as good as Medicare's), or leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription 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. 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 Anthem 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 Required to process your application.

Applicant signature X	**Today's date**
Desired plan effective date:	

Applicant Complete: Name _____ and Medicare Claim Number _____

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name		
Address		
City	**State**	**Zip Code**
Phone Number	**Relationship to Enrollee**	

Applicant: Please do not complete the following sections.
Agent/Broker: Please complete the following section carefully.

Coverage effective date _____

☐ IEP ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

PLAN ID #: _____

1. Was this an individual face-to-face appointment? ☐ Yes ☐ No (If 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 (If 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 _____

Applicant Complete: Name _____ and Medicare Claim Number _____

***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 date _____ _____ _____

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
BCLNGNPVMZ
___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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

External agent/broker's

Signature _____

Please complete all lines below.

Agent/broker's printed name
OLEG SKURSKIY

Agency name
18375 Ventura Blvd. # 226

Street address

City	State	Zip
TARZANA	CA	91356

Phone number 818 987 5000

Fax number 818 776 9865

Email address
ASKOLEG @ HOTMAIL.COM

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal.

Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare & 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.

Applicant Complete: Name _____ and Medicare Claim Number _____