


# SmartValue (PFFS)

## Individual Enrollment Request Form – 2010



**Be sure to complete the entire enrollment form.** Then, **mail** the completed form to agent Oleg Skurskiy  
 Oleg Skurskiy 18375 Ventura Blvd # 226 **Tarzana, CA 91356** or **fax** the completed form to: 1-818-776-9865.  
**Note:** Your agent/broker may provide different instructions.

**External Agents/Brokers:** Please see the External Agents/Brokers Section.

<b>Section 1: To enroll in SmartValue (PFFS), please provide the following information</b> <i>(please print clearly):</i>					
<b>Please check the plan you want to enroll in:</b>					
<input type="checkbox"/> SmartValue Plus (PFFS)* Monthly Premium: \$78		<input type="checkbox"/> SmartValue Classic (PFFS)** Monthly Premium: \$35			
* Includes Medicare Part D prescription drug coverage.		** Does not include Medicare Part D prescription drug coverage.			
Last Name		First Name		MI	Mr. Mrs. Ms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Phone No. ( ) ( )	Alternate Phone No. ( ) ( )		E-Mail Address	
Permanent Residence: Street Address (cannot use P.O. Box)			City	State	ZIP Code ____ - ____ + ____
Mailing/Billing Address (only if different from address above)			City	State	ZIP Code ____ - ____ + ____
<b>Section 2: Please provide your Medicare Insurance information.</b>					
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. <b>-or-</b> • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. <b>You must have both Medicare Part A and Part B to join a Medicare Advantage plan.</b> →					
			Name _____ Medicare Claim Number _____ Sex _____ _____ - _____ - _____ Is Entitled To: <b>Hospital (Part A)</b> _____ <b>Medical (Part B)</b> _____		
<b>Section 3: Paying Your Plan Premium</b>					
How would you like to pay your plan premiums? You can pay your monthly plan premium by mail or by automatic bank account deduction. You might also be able to pay your premium by automatic deduction from your Social Security benefit check each month <i>(see next page)</i> .					
<i>Section 3 continues on next page.</i>					

A health plan with a Medicare contract.

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al número telefónico que se muestra en el material adjunto. M0013\_08\_014 07/2007

Office Use Only: Date Stamp

**Section 3: Paying Your Plan Premium (continued)**

**Note:** People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of 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 can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

*If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or some portion of your plan premium. Because you might be responsible for paying part of your premium, you must choose a premium payment option. We must receive payment for any amount that Medicare doesn't cover.*

**Please choose one of the payment 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:** Deduct the amount 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: 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 monthly deduction of the amount from the account above.

**Automatic Social Security Deduction:** Deduct the amount 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 date withholding begins.)

**Section 4: Please Read and Answer These Important Questions:**

1. Do you have End Stage Renal Disease (ESRD)? .....  Yes  No  
Generally, if you answered "Yes," you are not eligible to enroll in this plan. However, if you answered "Yes" to this question but you no longer need regular dialysis or have had a successful kidney transplant, **please attach a note or records from your doctor** stating this.

2. *If you are enrolling in a plan that includes Medicare Part D prescription drug coverage, will you have other prescription drug coverage, such as other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs, in addition to the plan you are enrolling in?* .....  Yes  No

If "Yes," please list the name(s) of your other coverage and your identification (ID) number(s) for this coverage below. Name of other coverage \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

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

**Section 4 continues on next page.**

**Section 4: Please Read and Answer These Important Questions: (continued)**

**Certain** materials for your plan are available, *upon request*, in large print and **might** be available in Spanish. Check here if you would prefer to receive any of those materials in:  Spanish or  large print. Then, to request certain materials in large print or to find out if materials for your plan are available in Spanish, please call the Prospective Members' toll-free regular number, or TTY number, shown at the end of Section 1 of the enclosed Summary of Benefits. Our office hours are provided with the phone numbers.

**Section 5: Please Read This Important Information.**

SmartValue (PFFS), a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions, and may choose not to treat you, except in emergencies. Before each visit, you should verify that your provider(s) will accept SmartValue (PFFS). Providers can find the plan's terms and conditions on our website at [www.anthem.com/ca](http://www.anthem.com/ca).

Once Anthem Blue Cross (the Company) has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in SmartValue (PFFS). If the Company isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

**Please read if you are applying for a plan with Medicare Prescription Drug coverage: If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining this plan may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join SmartValue (PFFS). 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.

**Section 6: Attestation of Eligibility for an Enrollment Period**

**Typically, you may enroll in a Medicare Advantage (MA) Plan only during the Annual Enrollment Period (AEP) between November 15 and December 31 of each year. You can also join an MA plan during the MA Open Enrollment Period (MA-OEP) between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage.** Additionally, there are exceptions — i.e., Initial Enrollment Period (ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in an MA 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.

- |  |  |
|--|--|
| <input type="checkbox"/> I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)  | <input type="checkbox"/> I recently moved and this plan is a new option for me. (SEP) Date of move: _____ / _____ / _____<br>Mo. Day Year  |
| <input type="checkbox"/> I am enrolling during the MA Open Enrollment Period from January 1 to March 31. (MA-OEP)  | <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)   |
| <input type="checkbox"/> I am new to Medicare. (ICEP)<br>Eligibility Date: _____ / _____ / _____<br>Mo. Day Year   | <input type="checkbox"/> I get extra help to pay for Medicare prescription drug coverage. (SEP)  |
| <input type="checkbox"/> I recently moved outside of the service area for my current Medicare prescription drug plan. (SEP)<br>Date of move: _____ / _____ / _____<br>Mo. Day Year | <input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drug coverage. (SEP)<br>I stopped receiving extra help on: _____ / _____ / _____<br>Mo. Day Year |

**Section 6 continues on next page.**

**Section 6: Attestation of Eligibility for an Enrollment Period (continued)**

I will move into, now live in or recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP) Date of move: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

I recently left a PACE program (Program of All-inclusive Care for the Elderly) on date: \_\_\_\_/\_\_\_\_/\_\_\_\_. (SEP)  
Mo. Day Year

I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). (SEP) I lost my drug coverage on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

I am leaving employer or union coverage (SEP) on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

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. (SEP) I returned to the U.S. on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

None of these statements applies to me.\*

\* To see if you are eligible to enroll, please call the Prospective Members' toll-free regular number, or TTY number, shown at the end of Section 1 of the enclosed Summary of Benefits. Our office hours are provided with the phone numbers.

**Section 7: Please Read and Sign Below:**

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

The plan I am applying for is a Medicare Advantage Private Fee-For-Service (PFFS) plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private Fee-for-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Medicare Part D prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. If I am applying for a PFFS plan that does not include Medicare prescription drug coverage, I understand that I may get coverage from another Medicare prescription drug coverage plan. 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

As a Medicare Private Fee-For-Service plan, SmartValue (PFFS) works differently than a Medicare supplement plan, as well as other Medicare Advantage plans. SmartValue (PFFS) pays instead of Medicare, and I will be responsible for the amounts that SmartValue (PFFS) doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in SmartValue (PFFS).

Before seeing a provider, I should verify that the provider will accept SmartValue (PFFS). I understand that my health care providers have the right to choose whether to accept SmartValue's (PFFS) payment terms and conditions every time I see them. I understand that if my provider doesn't accept SmartValue (PFFS), I will need to find another provider that will.

The plan for which I am applying serves a specific service area. If I move out of the area that this plan serves, I need to notify Anthem Blue Cross (the Company) so I can disenroll and find a new plan in my new area. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (EOC) document from SmartValue (PFFS) when I get it to know the rules I must follow to get coverage in this Private Fee-for-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Company, he/she may be paid based on my enrollment in SmartValue (PFFS). Counseling services may be available

**Section 7 continues on next page.**

**Section 7: Please Read and Sign Below (continued):**

in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Company will release my information, including my prescription drug event data, if applicable, 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.

*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 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 enrollment and 2) documentation of this authority is available upon request by the Company or by Medicare.

<b>Signature*</b>	<b>Today's Date:</b>
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*\*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 _ _ _ _ _ + _ _ _ _ _

***Agents and Brokers: Please fill out the section on last page.***

Blue Cross of California, doing business as Anthem Blue Cross (Anthem), is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service (PFFS) plan(s) noted above or herein. Anthem is the risk-bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. Anthem has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region.

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