

4. Billing Choice (Please Check One)	<input type="checkbox"/> Monthly Electronic Fund Transfer - complete section 5 and attach a voided check or savings account deposit slip.	<input type="checkbox"/> Quarterly Paper Bill <input type="checkbox"/> Annual Paper Bill
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5. Electronic Fund Transfer Authorization (EFT) (This section must be completed if you want your monthly payments deducted directly from your checking or savings account.)

I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal each month from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.

Bank Name	Phone Number
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Bank Address	City/State/Zip Code
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Bank Information: Routing #	Account #
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Type of Account: (Check Only One): Checking Account (must attach voided check)
 Savings Account (must attach saving account deposit slip)

This authorization is to remain in effect until Anthem Blue Cross and Blue Shield has received at least 30 days prior written notification from me of a termination date.

6. SPOUSAL/DOMESTIC PARTNER DISCOUNT OPTION

We now offer a 5% Discount to all our members who are married or domestic partners and are both enrolled in any of our seven Anthem Medicare Supplemental Plans.

Fill out your spouse's/partner's information below.

Spouse's/Partner's Anthem ID# (if already a member) _____

Spouse's/Partner's Name _____

Spouse's/Partner's SS# _____

Spouse's/Partner's Address _____

7. REPLACEMENT OR OTHER COVERAGE INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

7. REPLACEMENT OR OTHER COVERAGE INFORMATION - CONTINUED

- (Please mark Yes or No below with an "X")
- | | YES | NO |
|--|--------------------------|--------------------------|
| (1) (a) Did you turn age 65 in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Did you enroll in Medicare Part B in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) If yes, what is the effective date? _____ | | |
| (2) Are you covered for medical assistance through the state Medicaid program?
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? | <input type="checkbox"/> | <input type="checkbox"/> |
| (3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START ___/___/___ END ___/___/___ | | |
| (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Was this your first time in this type of Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| (4) (a) Do you have another Medicare supplement policy in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) If so, with what company, and what plan do you have?
_____ | | |
| (c) If so, do you intend to replace your current Medicare supplement policy with this policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (5) Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union, or individual plan) | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If so, with what company and what kind of policy?
_____ | | |
| (b) What are your dates of coverage under the other policy?
START ___/___/___ END ___/___/___
(If you are still covered under the other policy, leave "END" blank.) | | |

8. DID YOU KNOW?

- You do not need more than **one** Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Signature required on back.

8. DID YOU KNOW? - CONTINUED

- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Call your local Social Security department or State Insurance Department for details.
- You should have Medicare hospital (Part A) coverage and **must** have Medicare medical (Part B) coverage and be 65 years of age or be eligible for Medicare disability coverage to enroll in a Medicare supplement plan. Benefits will only be payable to supplement the Medicare Programs in which you are enrolled.

9. NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicaid Advantage insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ANTHEM BLUE CROSS AND BLUE SHIELD:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits No change in benefits, but lower premiums
 - Fewer benefits and lower premiums
 - My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D
 - Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- _____
- Other (Please specify) _____

I certify that the foregoing information is true and complete to the best of my knowledge and belief. I further understand that no benefits will apply until the coverage is made effective by Anthem Blue Cross and Blue Shield. To prevent application processing delays and/or non-payment of claims, it is recommended that Anthem receive your application in advance of the 31st of the month for coverage to be effective the 1st of the following month.

I UNDERSTAND THAT FALSE AND/OR INCOMPLETE RESPONSES OR STATEMENTS MAY RESULT IN RESCISSION OF COVERAGE AND/OR NON-PAYMENT OF CLAIMS.

I understand this application shall become a part of my request for insurance. In order to process your application accurately, Anthem may need to contact you to obtain additional information or missing information.

_____	_____
SIGNATURE OF APPLICANT	DATE

_____	_____
SIGNATURE OF AGENT, PRODUCER OR OTHER REPRESENTATIVE (NOT REQUIRED FOR DIRECT RESPONSE SALES)	DATE
NAME AND ADDRESS OF ISSUER, AGENT OR PRODUCER	