

Anthem Blue Cross and Blue Shield Anthem Medicare Preferred



Medicare Advantage PPO Individual Enrollment Request Form – 2009

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

Enrollment Processing Center, P.O. Box 5007, Middletown, NY 10940-9007.

Section 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 <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	
Mailing/Billing Address (if different from address above)				City		State	ZIP Code

Section 2: Benefit Plan Selection	
<p>Note to Applicant: For information about the service areas and the premiums of the Medicare Advantage plans available to you, please refer to the Summary of Benefits enclosed with your enrollment materials.</p> <p>I wish to enroll in the plan checked here:</p> <p><input type="checkbox"/> Anthem Medicare Preferred Standard <input type="checkbox"/> Anthem Medicare Preferred Premier* These plans include Medicare Part D prescription drug coverage. (*Available only in Virginia)</p>	

Section 3: Please provide your Medicare Insurance information.							
<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> Please fill in the blanks at right so they match your red, white and blue Medicare card. <p>-or-</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. <p>You must have both Medicare Part A and Part B to join a Medicare Advantage plan. →</p>	<table border="1" style="width: 100%;"> <tr> <td style="text-align: center; border: none;"> </td> </tr> <tr> <td style="border: none;">Name _____</td> </tr> <tr> <td style="border: none;">Medicare Claim Number _____ Sex _____</td> </tr> <tr> <td style="border: none;">Is Entitled To: Hospital (Part A) _____</td> </tr> <tr> <td style="border: none;">Medical (Part B) _____</td> </tr> <tr> <td style="border: none;">Effective Date: _____</td> </tr> </table>		Name _____	Medicare Claim Number _____ Sex _____	Is Entitled To: Hospital (Part A) _____	Medical (Part B) _____	Effective Date: _____
Name _____							
Medicare Claim Number _____ Sex _____							
Is Entitled To: Hospital (Part A) _____							
Medical (Part B) _____							
Effective Date: _____							

Section 4: Please indicate if you prefer information in another language or format.
<p>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:</p> <p><input type="checkbox"/> 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.)</p> <p><input type="checkbox"/> In large print</p> <p>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.</p>

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

H1517, H1607, H4036,
H4909, H5529, H5530

SMUFR1686AM R11/08

(IN, KY, MO,
OH, VA, WI)

Office Use Only: Date Stamp

M0013_09_039 09/2008

Section 5: Paying Your Plan Premium.

If you are enrolling in a plan without any premium: If we determine that you owe a late enrollment penalty for the Medicare Part D prescription drug portion of your plan, we need to know how you would prefer to pay it. Please choose one of the payment options in the checklist below.

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 bank 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. However, because you might be responsible for paying part of your premium, you still must choose a premium payment option. We must receive payment 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.*)

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 (please check only one): Checking: Enclose a VOIDED check Savings: Enclose a VOIDED deposit slip.

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.*)
For savings account deposit slips that do not show a bank routing number, please obtain this number from your bank.

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 to the date withholding begins.*)

Section 6: Please Answer the Following 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. Do you or your spouse work? Yes No

3. Are you enrolled in your State Medicaid program? Yes No
If "**Yes**," please provide your Medicaid number: _____ and Effective date: _____

4. 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 Facility _____ Facility Phone no. (____) _____ Admission Date _____

Address of Facility _____
Street address City State Zip code

5. In addition to Anthem Medicare Preferred, 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?* 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 coverage _____ ID no. _____ Group no. _____

Section 7: Important — Please read.

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. 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 8: Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage (MA) Plan only during the Annual Open 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) from January 1 to March 31 of each year, as long as you do not change 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.

- I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)
- I am enrolling during the MA Open Enrollment Period from January 1 to March 31. (MA-OEP)
- I am newly eligible for Medicare. (ICEP)
Eligibility Date: ___/___/___
Mo. Day Year
- I recently moved outside of the service area of my current plan. (SEP) Date of move: ___/___/___
Mo. Day Year
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’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 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.*
- None of these statements applies to me.*
- I recently moved and this plan is a new option for me.
- I recently returned to the United States after living permanently outside of the U.S. (SEP)
- 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 left a Program of All-inclusive Care for the Elderly (PACE). (SEP)

* 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 ___

Section 9: Application Agreement Important: Read this information before signing in Section 10 on next page.

By completing this enrollment application, I agree to the following: Anthem Medicare Preferred is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform Anthem Blue Cross and Blue Shield (Anthem) of any prescription drug coverage that I have or may get 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 when an enrollment period is available (Example: November 15 – December 31 of every year), or under special circumstances.

The 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. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I agree that the Evidence of Coverage (EOC) document governs the rules that I must follow to receive coverage in this Medicare Advantage Plan. When I receive the EOC document from Anthem, I will read it so I know the rules to follow. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that, beginning on the date Anthem Medicare Preferred coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Anthem Medicare Preferred provides reimbursement for all covered benefits, even if received out of network. Services authorized by Anthem Medicare Preferred and other services contained in my Anthem Medicare Preferred Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Anthem Medicare Preferred will pay for the services.**

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.

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 Anthem Medicare Preferred.

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.

Section 9 continues on next page.

Standard Plan Members Only who reside in Indiana, Kentucky and Virginia: By joining the Anthem Medicare Preferred Standard 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 medical services or medical coverage, 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.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the health plan 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. **Note:** Failure to agree with all of the terms and conditions in the Release of Information statement above will result in a denial of your enrollment due to an inability to provide benefits and process claims.

Section 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

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H1517, H1607, H4036, H4909, H5529, H5530

Applicant: Please Do Not Complete the Following Sections. For Office and Agent/Broker Use Only.

Office Use — Internal Agents Only: Name/Code 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: **Please complete all lines below.**
 Date received from applicant: _____ Agent/Broker's Printed Name: _____
 I helped the applicant fill out this application: Yes No Agency Name: _____
 Please check the Code No. to use for commission payment: Address _____
 Agent/Broker's Code No.: _____ *Street address*
 Agency Code No.: _____ *City State ZIP code*
 Phone No.: () _____
 Fax No.: () _____
 E-Mail Address: _____

External Agent/Broker's
 Signature _____
 Date _____

Page 4 of 4 **For Applicant to Complete:** Name _____ & Medicare ID# _____

These plans are PPOs with a Medicare contract.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area), RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Virginia (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123): Anthem Health Plans of Virginia, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies, and CompCare Health Services Insurance Corporation ("CompCare"), which underwrites or administers the HMO policies; CompCare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. *ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. *The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.