

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:
Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly.

Step 3

SEND THE COMPLETED APPLICATION TO:

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...



Section 3 – Health History

You must already be enrolled in Medicare Parts A and B to apply for these plans. All applicants must complete sections 3 and 4. If the answer to any of the following questions is “Yes”, you are not eligible for coverage. We will not deny coverage to any individual who applies for coverage if you are applying from certain Anthem Plans that are not Medicare Supplements or if you are applying within six (6) months of your initial enrollment in Medicare Part B.

--Applicants age 65 or older must complete this section:

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a walker or wheelchair? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements.) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin's disease, coronary artery disease, heart attack, nephritis, kidney failure, stroke, or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past 5 years have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, organ transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight? | <input type="checkbox"/> | <input type="checkbox"/> |

Applicants under age 65 must complete this section:

- | | | |
|--|--------------------------|--------------------------|
| A. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a walker or wheelchair? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements.) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin's disease, arteriosclerosis, coronary artery disease, heart attack, nephritis, stroke, Alcoholism, drug abuse, brain disorder, Chronic brain syndrome, lung disorder requiring use of oxygen, Neuromuscular disorder, cerebral palsy, an amputation due to disease, Systemic lupus, sickle cell or aplastic anemia, scleroderma, polycythemia or hemophilia? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past 5 years have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, nervous mental disorders, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, enlarged heart, congestive heart failure, peripheral vascular disease, heart valve replacement, placement of pacemaker, open heart surgery or angioplasty, aneurysm, organ transplant (except cornea), cirrhosis of the liver, insulin dependent diabetes, complications of diabetes such as amputation or loss of sight or any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), or emphysema (excluding allergies and asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you ever experienced, been told you have, consulted for treatment of, sought treatment for, had treatment recommended for, received treatment for (including drug therapy) or been hospitalized for End Stage Renal Disease? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 3 – Health History (continued)

- G. Within the last 36 months, have you ever experienced, been told you have, consulted for treatment of, sought treatment for, had treatment recommended for, received treatment for (including drug therapy) or been hospitalized for Chronic Renal Failure, Polycystic Kidney Disease, Kidney transplantation or any form of Kidney dialysis? Yes No

Section 4 – Medical Information

Name of Primary Care Physician _____ Telephone (_____) _____

Address _____

List all prescription drugs currently prescribed for your use: (If none, write “none”) _____

List name, address and telephone number of prescribing physician if different from above:

Section 5 – Conditions of Application

Please read the following carefully.

- A. I agree to pay an application fee equal to the subscription charges required for the program requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the subscription charges if my application is accepted.
- B. Anthem has the right to reject my application. If Anthem rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if Anthem rejects my application, under no circumstances will any Anthem benefits be payable.
Cashing of my check by Anthem does not constitute approval of my application.
- C. If my application is accepted, this application will become part of the agreement between Anthem and myself. If this application is accepted, I further agree to be bound by the arbitration clause set forth in Section 7 of this application and I waive my right to court trial by judge or jury in the event of any dispute arising under this policy.
- D. Anthem may request additional information, which may delay processing of this application. If the health care provider bills for this information, Anthem will pay up to \$25 and I understand that I will be responsible for any difference.
- E. The selling agent has no authority to promise me coverage or to modify Anthem underwriting policy or terms of any Anthem coverage.
- F. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted and that Anthem may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions regarding my past or present health conditions.
- G. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Important Information for Applicant (Please read)

- 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 or may not need a Medicare supplement policy.
- If, after purchasing the 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.
- 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).

Section 6 – Authorization & Agreements

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex), but not including psycho therapy notes.

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Anthem Blue Cross and Blue Shield or affiliate ("Anthem") its agents, employees, designees, or representatives, including my Anthem agent or broker, for the purpose(s) described below.

Section 6 – Authorization & Agreements (continued)

Purpose of this Authorization: By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Effect of Declining: If I decide not to sign this authorization, you may decline to enroll me in our health plan. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon termination of any Anthem coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

**Anthem Blue Cross and Blue Shield
PO. Box 9063, Oxnard, CA 93031-9063
Telephone 1-866-438-9969, Fax 1-805-375-0361**

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

If the authorization is signed by a personal representative, on behalf of the individual, complete the following:

<input type="text"/>	X <input type="text"/>	<input type="text"/>
Print Applicant's Name	Applicant's Signature	Date

Name of the other person or persons authorized to receive my PHI:

<input type="text"/>	<input type="text"/>
Name of other person authorized to use or disclose my PHI	Relationship to Applicant

X <input type="text"/>	<input type="text"/>
Applicant's Signature	Date

A photocopy of this authorization is as valid as the original, and I and my Anthem agent or broker are entitled to receive a copy of this form. I AM ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER I SIGN IT.

I have personally read and completed this application. I understand and agree to the Replacement Notification, the Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare" and "Outline of Medicare Coverage and Premium Information" as required. I understand that receipt of money with this application does not create Anthem coverage. Coverage will come into effect only if this application is approved by Anthem Blue Cross and Blue Shield.

I, the applicant, acknowledge that I have read and understand this Application in its entirety.

Section 7 – General 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.

To the best of your knowledge,

- 1. a. Did you turn age 65 in the last 6 months? Yes No
- b. Did you enroll in Medicare Part B in the last 6 months? Yes No
- 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.] Yes No

If yes,

- a. Will Medicaid pay your premiums for this Medicare supplement policy? Yes No
- b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

- 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? Yes No
- c. Was this your first time in this type of Medicare plan? Yes No
- d. Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No

- 4. a. Do you have another Medicare supplement policy in force? Yes No
- 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? Yes No

- 5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes No

a. If so, with what company and what kind of policy? _____

b. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave “END” blank.
START ____/____/____ END ____/____/____

Optional Monthly Checking Account Deduction Authorization for Seniors.

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of ANTHEM BLUE CROSS AND BLUE SHIELD provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Subscriber	
Group Number	
X	Date

Social Security Number	
Bank Name	
X	Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

For Agent Only

Please list any other health insurance policies you have issued to the applicant that are still in force and any other health insurance policies issued in the past 5 years that are no longer in force and submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
_____	_____	_____
From: Mo./Yr.		Name
_____		_____
		Address

		City/State

To: Mo./Yr.		(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the applicant the “Guide to Health Insurance for People with Medicare” and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

	SIGNED AT	
Agent’s Signature	Date of Signature	(City and State)
_____	_____	_____
Print Agent’s Name	Agent No.	
_____	_____	
Street Address	Telephone No.	
_____	_____	
City	State	ZIP
_____	_____	_____

Amount Paid With Application \$ _____
Send Agreement and I.D. Card To: Agent Subscriber

Name of person who completed this application: _____

Please return application to agent by mail or fax to:
Oleg Skurskiy
18375 Ventura Blvd. # 226 Tarzana , CA 91356

By Fax: 1-818-776-9865



An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association.

PRIORITY PROCESSING

Complete the Other Side of this form to enroll in the Optional Monthly Checking Account Deduction Authorization for Seniors.

Include with one month’s dues in application pocket behind check.

Include a blank check marked “VOID”.

A deposit slip is not acceptable.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Anthem Blue Cross and Blue Shield
P.O. Box 9063, Oxnard, CA 93031-9063

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

According to the information you have furnished, you intend to terminate existing Medicare supplement or Medicare 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.

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 or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

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 (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) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.