

# 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.**

## **Step 3**

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: Anthem Blue Cross**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

**Thank you for choosing...**





**SENIOR ENROLLMENT APPLICATION**  
**For Seniors with Medicare Parts A and B**  
 Please complete entire application.

Application for a Medicare SELECT Plan or Standard Plan A to supplement Medicare (Select one)

- Blue Cross Senior Classic<sup>SM</sup> C   
  Blue Cross Senior Classic F   
  Blue Cross Senior Classic I  
 Blue Cross Senior Classic J   
  Standard Plan A

A two-party contract (Member and Spouse rate) is available for eligible couples, at their option.  
 Both spouses must be age 65 or older, enrolled in both Parts A and B of Medicare, and apply for the same plan.

If you and your spouse are applying for a two-party contract, please check this box:  Yes

If yes, you and your spouse will each have to fill out your own application, list the other spouse's name and Social Security Number, and submit both applications together.

Name of Your Spouse \_\_\_\_\_

Your Spouse's Social Security Number \_\_\_\_\_

Please enclose only one check for the applicable rate for the two of you.

**Section 1 – Applicant Information**

This complete original application will be returned to you, for your records, along with your certificate, when you are enrolled.

**Please copy the information from your Medicare card here**

↓

NAME OF BENEFICIARY \_\_\_\_\_

CLAIM NUMBER \_\_\_\_\_ SEX \_\_\_\_\_

IS ENTITLED TO \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

HOSPITAL INSURANCE \_\_\_\_\_

MEDICAL INSURANCE \_\_\_\_\_

Requested effective date, or end date of prior Medicare supplement, if replacing

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name (as it appears on your Medicare card)

Social Security Number

Home Address, Apt. No., Suite No.

City

State

Zip

Billing Address (if different from home address)

City

State

Zip

Care of/Attention

Home Telephone Number  
( )

E-mail Address

Date of Birth

If transferring from another Anthem Blue Cross Group/Individual or Blue Cross/Blue Shield out-of-state plan, indicate →

Group Number

State

Identification Number

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer (EFT) from your account or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

*If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling toll-free 1-888-211-9813.*

*Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando a 1-888-211-9813.*

**Please enclose check for one month premium.**

**If you are applying for a 2-party contract, or wish to be added to an existing contract, please enclose one check for the applicable 2-party rate.**



## Guaranteed Issue Rights Notice

**Before answering any Health History or Medical Information Questions, please read this important information regarding Medicare Supplement Guaranteed Issue rights.**

**You are not required to provide health information during a period of guaranteed issuance.** You are not required to answer the Health History or Medical information questions in this application if you are entitled to a guaranteed issue Medicare Supplement Plan. If you qualify for enrollment on the basis of guaranteed issue, you will not be denied coverage.

You will not be required or requested to sign a form required by the Federal Health Insurance Portability and Accountability Act of 1996.

Please refer to the attached **Medicare Supplement Guaranteed Issue Guideline** to determine if you qualify for Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan.

If you think you qualify for guaranteed acceptance into an Anthem Blue Cross Medicare Supplement Plan please write the number of the qualifying situation, as described in the Medicare Supplement Guaranteed Issue Guideline, in the Box below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

**I believe I qualify for guaranteed acceptance based on situation number**

Please note: Guaranteed acceptance does not apply to Anthem Blue Cross Senior SmartChoice PLUS (High deductible Plan F with Rider).

For more information about guaranteed acceptance, please contact Anthem Blue Cross Senior Services at the following toll-free number:

**(800) 333-3883**

Monday – Friday:  
8:00 a.m. to 6:00 p.m.

Or, contact your Anthem Blue Cross Agent.

You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California Citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

# Medicare Supplement Guaranteed Issue Guideline

**Important:** Please note this Guide is only a summary, and is intended to help you identify the different situations that may qualify you for a Guaranteed Acceptance into Anthem Blue Cross Medicare Supplement Plan.

## The Initial Enrollment Period for Part B is:

- ◆ 7 months, starting 3 months before you turn 65 and ending 3 months after the month of your birthday. If you do not enroll during this period, you will have to wait until the next General Enrollment Period.

## The General Enrollment Period for Part B is:

- ◆ January 1 to March 31 each year. Medicare coverage will be effective the following July 1st.

## Special Enrollment for Part B

- ◆ Part B enrollment may be delayed if you are over age 65 and have group health insurance as a result of your current employment or your spouse's current employment that provides group health insurance; or, you are disabled and have group health insurance based on yours or any family member's current employment.
- ◆ In any of these instances, you will qualify for a special 6-month enrollment period beginning the month after the termination of your group-sponsored coverage. If you do not enroll by the end of this grace period, you will have to wait until the next General Enrollment Period.

## Guaranteed Issue

Listed below are situations in which a Medicare applicant/member has the right to purchase a Medigap policy. These rights are commonly called guaranteed issue (GI) rights. In these circumstances, acceptance into a Medicare Supplemental policy is guaranteed regardless of the applicant's medical condition(s).

### Situations

- 1. Part B effective date:** You are eligible for Guaranteed issue if you are at least 65 years of age and apply for a Anthem Blue Cross Medicare Supplement Plan prior to or during the six-month period beginning with the first day of the month of your Part B effective date. You must submit evidence that you have Medicare Parts A and B with your application.
- 2. Disabled and receiving Medicare benefits prior to your 65<sup>th</sup> birthday:** Upon your 65<sup>th</sup> birthday you will receive a 6-month Guaranteed Issue period beginning with the date of your 65<sup>th</sup> birthday. Excludes End Stage Renal Disease members. You must submit evidence that you have Medicare Parts A and B with your application.
- 3. Termination of coverage under a group-sponsored health plan:** If you are receiving health care coverage through your group employer and you decide to terminate the group plan, you are entitled to a 6-month Guaranteed Issue period beginning on the date of termination. You must provide proof of disenrollment with your application.
- 4. Medicare Advantage (MA) coverage ends due to the Plan leaving the program or area:** You have 123 days as of the date of termination to select a Medigap plan from any company in the area. If you have relocated to an area where the company does not have a plan, you are entitled to a guaranteed issue period for 123 days. You must provide proof of disenrollment with your application.

**5. Termination of health care for military retiree or spouse or dependents due to military base closure, base no longer offers services, or you relocated:** If you are a Medicare-eligible military retiree or dependent and at least 65 you are entitled to a 6-month guaranteed issue period beginning the date you lost health care services at the military base. You must provide proof of prior insurance with your application.

**6. Upon becoming eligible for Medicare benefits at age 65, you enrolled in a MA plan and then disenrolled within 12 months:** You are entitled to the lesser of 63 days or the 1 year anniversary of your enrollment in MA as a guaranteed issue period beginning with date of disenrollment from the MA plan. You must provide proof of prior insurance with your application.

**7. Disenroll from a Select, Pace or MA plan within 1 year of leaving a Medigap policy for the first time.** You are entitled to re-enroll in your original Medigap policy within the lesser of 63 days or the 1year anniversary of your enrollment in MA beginning with the date of termination. This must be your first time enrolled in a Select, Pace, or MA plan. You must provide proof of prior insurance with your application.

**8. Birthday Rule:** You are entitled to acceptance into equal or lesser value plans for 30 days beginning on your birthday. You must have a Medicare Supplement Plan and you must provide proof of prior coverage with your application.

**9. Leave your plan as a result of fraud committed by the plan:** You are entitled to a 63-day guaranteed issue period beginning with the latter of the date of termination or the fraud determination date. You must provide proof of prior coverage and provide a determination letter stating the plan was at fault with your application.

**10. Your MA plan, reduces benefits, increases the cost sharing amount, or discontinues a provider for other than good cause:** If any one of these events occur you are entitled to a guaranteed issue period of 63 days. You must provide proof of prior coverage with your application.

I acknowledge receipt of the Guaranteed Issue Rights Notice and the Medicare Supplement Guaranteed Issue Guideline. I have had full opportunity to read and consider my Medicare Supplement Guaranteed Issue Rights.

_____	_____	_____
Print Applicant's Name	Applicant's Signature	Date

_____	_____	_____
Print Agent/Broker Name	Agent/Broker Signature	Date

\_\_\_\_\_  
Agent/Broker ID

### Section 3 – 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:

If applying for, but not accepted for **Blue Cross Senior Classic I** or **Blue Cross Senior Classic J**,  
if I qualify, I would like to be enrolled in:

**Blue Cross Senior Classic F**

or

**Blue Cross Senior Classic C**

### Section 4 – 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:

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? \_\_\_\_/\_\_\_\_/\_\_\_\_

D. Are you covered for medical assistance through California’s Medi-Cal program?

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program,  
please answer NO to this question.  Yes  No

If yes,

i. Will Medi-Cal pay your premiums for this Medicare supplement policy?  Yes  No

ii. Do you receive any benefits from Medi-Cal OTHER THAN payments  
toward your Medicare Part B premium?  Yes  No

E. 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

i. 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

ii. Was this your first time in this type of Medicare plan?  Yes  No

iii. Did you drop a Medicare supplement policy to enroll in this Medicare plan?  Yes  No

F. Do you have another Medicare supplement policy in force?  Yes  No

i. If so, with what company, and what plan do you have? \_\_\_\_\_

## Section 4 – General Information (continued)

- ii. If so, do you intend to replace your current Medicare supplement policy with this policy?  Yes  No
- G. Have you had coverage under any other health insurance within the past 63 days?  Yes  No  
(For example, an employer, union, or individual plan)
- i. If so, with what company and what kind of policy? \_\_\_\_\_  
\_\_\_\_\_
- ii. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

Please be aware that if you are currently enrolled in a Medicare Advantage plan, it is your responsibility to terminate your coverage prior to enrollment becoming effective with Anthem Blue Cross. Any unpaid claims resulting from failure to disenroll from your Medicare Advantage plan will be your responsibility.

## 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. If I do not qualify for guaranteed acceptance into an Anthem Blue Cross Medicare Supplement Plan, Anthem Blue Cross has the right to reject my application. If Anthem Blue Cross 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 Blue Cross rejects my application, under no circumstances will any Anthem Blue Cross benefits be payable. ***Cashing of my check by Anthem Blue Cross does not constitute approval of my application.***
- C. If my application is accepted, this application will become part of the agreement between Anthem Blue Cross and myself. If this application is accepted, I further agree to be bound by the binding arbitration clause set forth in 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 Blue Cross may request additional information, which may delay processing of this application. If the health care provider bills for this information, Anthem Blue Cross 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 Blue Cross underwriting policy or terms of any Anthem Blue Cross coverage.
- F. I alone am responsible for reading and accurately completing this application. I understand that coverage under the contract will be voided only in the event that I fail to accurately respond to questions regarding my past or present health condition. 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 Blue Cross 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. California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.**

### Important Information for Applicant (Please read)

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare supplement policy.

## Section 5 – Conditions of Application. (continued)

4. If, after purchasing the policy, you become eligible for Medi-Cal or Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or 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 Medi-Cal or 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.
5. 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 after 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.
6. 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 Medi-Cal or Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.

## Section 6 – Binding Arbitration

**Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. The Member and Anthem Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.**

**California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."**

**The Member and Anthem Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross and Anthem Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member. The arbitration findings will be final and binding except to the extent that state or federal law provides for the**

## Section 6 – Binding Arbitration (continued)

judicial review of arbitration proceedings. The arbitration is initiated by the Member making written demand on Anthem Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the costs of the arbitration. Please send all Binding Arbitration demands in writing to:

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

X

Applicant's Signature

Date of Signature

## Section 7 – 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 psychotherapy 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 or affiliate ("Anthem") its agents, employees, designees, or representatives, including my Anthem Blue Cross agent or broker, for the purpose(s) described below.

**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. *Exception:* If you qualify for Guaranteed Acceptance into this plan, you are not required to sign this authorization and we will not decline to enroll you in this plan.

**Effect of Declining:** If you decide not to sign this authorization, we may decline to enroll you 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. *Exception:* If you qualify for Guaranteed Acceptance into this plan, you are not required to sign this authorization and we will not decline to enroll you in this plan.

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

*(This section is continued on next page)*

**Section 7 – Authorization & Agreements (continued)**

**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  
PO. Box 9063, Oxnard, CA 93031-9063  
Telephone 1-800-333-3883, Fax 1-805-375-0361**

I understand that revocation of this authorization will not affect 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.

<b>X</b>	<b>X</b>	
<b>Print Name</b>	<b>Signature</b>	<b>Date</b>

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. **YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**

- I have personally read and completed this application. I understand and agree to the Replacement Notification on page 11 of this application and to the Conditions of Application and the Authorization & Agreements in this application. I acknowledge receipt of the “Guide to Health Insurance for People with Medicare”, the Provider Directory, and the Blue Cross Senior Classic F Plan with the AdvantageCare Rider brochure, which includes the Medicare Select Disclosures, Grievance Procedures, “Outline of Coverage” and Premium Information.
- I acknowledge receipt of the Medicare Supplement Guaranteed Issue Guideline and I have had full opportunity to read and consider my Medicare Supplement Guaranteed Issue Rights.
- I understand that receipt of money with this application does not create Anthem coverage. Coverage will come into effect only if Anthem Blue Cross approves this application.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety.

<b>X</b>	<b>X</b>	
<b>Print Name</b>	<b>Signature</b>	<b>Date</b>

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer line toll-free at 1-800-927-HELP, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free at 1-800-434-0222, or by accessing the Department of Insurance's web site [www.insurance.ca.gov](http://www.insurance.ca.gov).

**For Agent Only**

Please list all disability policies you have issued to the applicant that are still in force and all disability policies issued in the past 5 years that are no longer in force and submit with the application, as required by Insurance Code Section 10197(c):

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," the Medicare Supplement Guaranteed Issue Guideline 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: <input type="checkbox"/> Agent <input type="checkbox"/> Subscriber		
Name of person who completed this application: _____		

**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 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 Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross 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
<b>X</b> Date

Social Security Number
Bank Name
<b>X</b> Date

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

## Section 8 – Authorization & Agreements

The following authorization is voluntary.

Only complete the section below if you wish to disclose your Private Health Information (PHI) to a third party (spouse, family member, or any other individual). Signing this form will allow a third party the ability to call for information regarding your application or claims.

### SECTION A: Individual authorizing use and/or disclosure

Name	Telephone
Address	Member Identification Number

### SECTION B: The use and/or disclosure being authorized

PHI to be Used and/or Disclosed: **(Specifically describe the PHI to be used and/or disclosed)**

Check if this authorization is for psychotherapy notes.

**If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information (PHI).**

Entities or Persons Authorized to Use or Disclose: **(Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above).**

Anthem \_\_\_\_\_

Entities of Persons Authorized to Receive: **(Name or specifically identify the persons and/or organizations {or the classes of persons and/or organizations}, including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above).**

Anthem \_\_\_\_\_

#### Purpose of this Authorization:

- At request of individual
- For the following purposes:

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

**SECTION C: Expiration and revocation**

Expiration: This authorization will expire (complete one)

On \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized).

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

\_\_\_\_\_  
Anthem Blue Cross

Contact Office

\_\_\_\_\_  
1-800-333-3883

Telephone

\_\_\_\_\_  
1-805-375-0361

Fax

\_\_\_\_\_  
P.O. Box 9063 Oxnard, CA 93031-9063

Address

**INDIVIDUAL'S SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Personal Representative's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Individual

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

## Replacement Notification

WE ADVISE YOU TO SAVE THIS NOTICE AS IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you have furnished, you intend to lapse or otherwise terminate an existing Medicare supplement policy or Medicare Advantage plan and replace it with a contract to be issued by Anthem Blue Cross. Your plan contract to be issued by Anthem Blue Cross will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Standard Plan A or Medicare Select coverage is a wise decision.

**Statement to applicant by plan, solicitor, solicitor firm, or other representative:**

**A.** You have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of your knowledge. The replacement contract 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.) \_\_\_\_\_

**B.** You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.

**C.** State law provides that your replacement Medicare Select or Standard Plan A contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

**D.** If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and refund your prepaid or periodic payment as though your contract 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.

**E.** Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.



Anthem Blue Cross  
Toll-Free Number

Monday – Friday:  
8:00 a.m. to 5:00 p.m.

***1-888-211-9813***

**MAILING ADDRESS – Applicant: Please return application to agent or mail to:**

**Enrollment Processing Center**

P.O. Box 5007

Middletown, NY 10940-9007

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