



Blue Cross MedicareRxSM Medicare Prescription Drug Plan Individual Enrollment Form — 2007

Mail completed application to:

Oleg Skurskiy
18375 Ventura Blvd # 226
Tarzana , CA 91356

By fax : 818-776-9865

If you have any questions please call 818-654-4548

** If applicant wishes to pay by automatic bank withdrawal,
be sure to include applicant's completed "Automatic Payment Options" form.*

Blue Cross of California is an Independent Licensee of the Blue Cross Association (BCA).
Anthem Insurance Companies, Inc (AICI) is the legal entity under contract with the Centers for Medicare and Medicaid Services (CMS) and
licensed under state law or under a federal waiver program to offer the applicable Medicare Prescription Drug (Part D) plans in this region.
AICI has partnered with affiliated companies to provide services for these plans.

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Blue Cross MedicareRx

Medicare Prescription Drug Plan Individual Enrollment Form — 2007



Step 1: Please provide information about you. (Please print clearly.)

Last name										First name										MI		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.						
Permanent residence street address															City										State		ZIP code	
Social Security number (optional)					Date of birth ____/____/____					Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					Home phone number ()													
Mailing address (only if different from your permanent residence address)																												
Street/P.O. Box										City										State		ZIP code						

Important: Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs?
 Yes **No** If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask you for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.Medicare.gov or call 1-800-MEDICARE.

Step 2: Please select a Benefit Plan — Choose only one.

<input type="checkbox"/> Blue Cross MedicareRx Value					<input type="checkbox"/> Blue Cross MedicareRx Plus					<input type="checkbox"/> Blue Cross MedicareRx Gold				
Monthly Premium: \$19.00					Monthly Premium: \$25.00					Monthly Premium: \$34.60				

Step 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 these blanks 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 Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<div style="text-align: center; border: 1px solid black; padding: 5px;"> </div> <p>Name _____</p> <p>Medicare Claim Number _____ Sex _____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To: _____ Effective Date: _____</p> <p>Hospital (Part A) _____</p> <p>Medical (Part B) _____</p>
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Step 4: Please read this important information.

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Blue Cross MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Blue Cross MedicareRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue Cross MedicareRx 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 may be able to help.

Step 5: Please select your plan premium payment option. (Applicant **must** check “Yes” or “No,” below.)

You have several options for your monthly premium payment. You can check “Yes,” below, to have your premium for this Medicare drug plan automatically deducted from your Social Security payment. Or, you can complete the separate Automatic Payment Option form to have your premium automatically withdrawn from your bank account. Any of these options could result in several months’ premium being deducted for your **first** payment. If you do not choose one of these payment options, we will send you a bill each month, to pay by mail. Generally, you must stay with the payment option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if any, deducted from your SSA monthly benefit check.

All Applicants:

Would you like the premium for this prescription drug plan deducted from your monthly SSA benefit payment? **Yes** **No**

Step 6: Please answer the following questions to help Medicare coordinate your benefits.

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Blue Cross MedicareRx? **Yes** **No** *If yes, please list your other coverage and your identification (ID) number(s) for this coverage.*

Name of other coverage _____

ID number _____ Group number _____

2. 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 Institution _____

Address of Institution _____

Phone number of Institution (_____) _____

Step 7: Please provide your Enrollment Period information.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Open Enrollment Period (AEP) between November 15 and December 31 of each year — unless you are newly eligible for Medicare (in your Initial Enrollment Period, or IEP) *or* you are eligible for a Special Enrollment Period (SEP). Please check any statement below that is true for you.

I am new to Medicare. (IEP)

I recently moved outside of the service area for my current plan. (SEP)

I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)

I was recently approved for extra help paying for Medicare prescription drug coverage. (SEP)

I just moved into a long-term care facility (for example, a nursing home or longer-term care). (SEP)

I recently left a PACE program. (SEP)

I recently involuntarily lost my creditable drug coverage (that is, coverage that is at least as good as Medicare’s). (SEP)

I am either losing coverage I had from an employer or leaving employer coverage. (SEP)

If none of these statements apply to you, or if you are not sure, call 1-800-928-6201 to see if you are eligible to enroll. TTY/TDD users should call 1-877-247-1657 These numbers are available from 8 a.m. to 8 p.m., 7 days a week.

Step 8: Please read and sign on the next page.

By completing this enrollment application, I agree to the following: Blue Cross MedicareRx is a Medicare drug plan and is in addition to my coverage under Medicare. Therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Blue Cross MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Blue Cross MedicareRx or by calling 1-800-MEDICARE. TTY/TDD users should call 1-877-486-2048. These numbers are available 24 hours a day, 7 days a week.

Step 8 is continued on the next page.

Blue Cross MedicareRx serves a specific service area. If I move out of the area that Blue Cross MedicareRx serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue Cross MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. When I receive the Evidence of Coverage document from Blue Cross MedicareRx, I will read it so I know the rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that Blue Cross MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. 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.

Blue Cross MedicareRx Gold Plan Members Only: By joining the Blue Cross MedicareRx Gold 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 prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.

Be sure to sign below: I have read and understand the contents of this application, as indicated by my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I live).

If signed by an authorized individual (as described above), this signature certifies that this person is authorized under State law to complete this enrollment. I understand that proof of this authorization (Durable Power of Attorney or Guardianship papers) must be attached to this application.

Your Signature* _____ **Today's Date** _____

**If you are the authorized representative, you must attach proof of your authorization and provide the following information:*

Name _____ Address _____

Phone number _____ Relationship to Enrollee _____

If anyone helped the individual fill out this form, he or she must sign below.

Signature _____ **Relationship** _____ **Date** _____

Applicant: Please do not complete the following section. For Agent/Broker Use Only.

Note: The effective date shown below should be the first of the next month after we receive the application — unless a different future date is requested for a qualified applicant in an IEP or an SEP. If applicant applies during an AEP, the effective date should be January 1st of the following year.

Proposed Effective Date (mo / day / yr) : _____

Enrollment Period (*check one*):

IEP (Initial Enrollment Period)

SEP (Special Election Period) If checked, give date of SEP event : _____

AEP (Annual Coordinated Election Period)

I have assisted the applicant in filling out this application:

Yes No

Agent Use Only

Signature _____

Date _____

Office Use

Please check which code to use for commission payment:

Agent/Agency Code No.: BCLNGNPVMZ

Sub Agent Code No.: _____

Agent/Broker's

Printed Name: Oleg Skurskiy

Agency Name: _____

Address 18375 Ventura Blvd # 226

Street address

Tarzana CA, 91356

City

State

ZIP code

Phone No.: (818) 987-5000

Fax No.: (818) 776-9865

E-Mail Address: oleg@askoleg.com

Medicare Prescription Drug Plan Use Only: Plan ID# _____

White Copy: Return to Blue Cross of California Yellow Copy: Applicant Should Keep Pink Copy: Agent/Broker