

**Please print out the form below and mail  
your signed completed form to:**

**Oleg Skurskiy  
18375 Ventura Blvd. #226  
Tarzana , CA 91356**

**You also can fax complete application to Fax: (818) 776-9865**

If you have questions or need assistance with your application, please call 1-818-654-4548

Application is for following counties only:

Alameda, Sacramento, Santa Clara, and Stanislaus Counties

We are licensed only in the states:

California, Colorado, Nevada, Arizona, Texas, Illinois, Ohio, Virginia, Georgia, Connecticut ,  
New Hampshire, Oregon

If you are out of the state above, please call 1-800 medicare

# Anthem Medicare Preferred (PPO)

## Individual Enrollment Request Form – 2012



**Be sure to complete the entire enrollment form.** Then, mail the completed form to **Oleg Skurskiy**  
 18375 VENTURA BLVD # 226 or fax the completed form to **18187769865** You can also enroll online  
 TARZANA, CA 91356 . **Note:** Your agent/broker may provide different instructions.

Please contact Anthem Blue Cross Life and Health Insurance Company if you need information in another language or format (Large Print or Braille).

**To enroll in Anthem Medicare Preferred (PPO), please provide the following information.**

**Please check which plan you want to enroll in:**

**Anthem Medicare Preferred Standard (PPO)**  
 \$131.00 per month

**Preventive Dental Package**  
 \$12.00 per month\*\*

**Comprehensive Dental and Vision Package**  
 \$32.00 per month\*\*

**Combination Package**  
 \$45.00 per month\*\*

\*\* This premium is in addition to your monthly plan premium.

<b>Last name</b>	<b>First name</b>	<b>Middle initial</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
<b>Birth date</b> ( __ / __ / ____ ) ( M M / D D / Y Y Y Y )	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Home phone number</b> (   )	<b>Alternate phone number</b> (   )
<b>Permanent residence street address</b> (P.O. Box is not allowed.)			
<b>City</b>	<b>State</b>	<b>ZIP code</b>	<b>County</b>
<b>Mailing address</b> (only if different from your permanent residence address)			
<b>Street address</b>	<b>City</b>	<b>State</b>	<b>ZIP code</b>
<b>Email address</b>			

**Please provide your Medicare insurance information.**

<p>Please take out your red, white and blue Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>· Please fill in these blanks so they match your Medicare card.</li> <li>- OR -</li> <li>· Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">MEDICARE</td> <td style="width: 50%; text-align: center;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="2" style="text-align: center;"> </td> </tr> <tr> <td colspan="2" style="text-align: center;">SAMPLE ONLY</td> </tr> <tr> <td colspan="2">Name _____</td> </tr> <tr> <td>Medicare Claim Number _____</td> <td>Sex _____</td> </tr> <tr> <td colspan="2">_____ - _____ - _____</td> </tr> <tr> <td>Is Entitled To</td> <td>Effective Date</td> </tr> <tr> <td><b>HOSPITAL (Part A)</b></td> <td>_____</td> </tr> <tr> <td><b>MEDICAL (Part B)</b></td> <td>_____</td> </tr> </table>	MEDICARE	HEALTH INSURANCE			SAMPLE ONLY		Name _____		Medicare Claim Number _____	Sex _____	_____ - _____ - _____		Is Entitled To	Effective Date	<b>HOSPITAL (Part A)</b>	_____	<b>MEDICAL (Part B)</b>	_____
MEDICARE	HEALTH INSURANCE																		
SAMPLE ONLY																			
Name _____																			
Medicare Claim Number _____	Sex _____																		
_____ - _____ - _____																			
Is Entitled To	Effective Date																		
<b>HOSPITAL (Part A)</b>	_____																		
<b>MEDICAL (Part B)</b>	_____																		

**Applicant Complete:** Name \_\_\_\_\_ and Medicare ID number \_\_\_\_\_











