

# Blue Cross Senior Secure<sup>SM</sup> (HMO) Individual Enrollment Request Form – 2010



**Be sure to complete the entire enrollment form.** Then, **mail** the completed form to agent Oleg Skurskiy  
Oleg Skurskiy 18375 Ventura Blvd. # 226 Tarzana, CA 91356 **or fax** the completed form to: 1-818-776-9865.  
**Note:** Your agent/broker may provide different instructions.

**External Agents/Brokers:** Please see the External Agents/Brokers Section.

<b>Section 1: To enroll in Blue Cross Senior Secure (HMO), please provide the following information (please print clearly):</b>					
<b>Please check the plan you want to enroll in:</b>					
<input type="checkbox"/> Blue Cross Senior Secure Plan I (HMO)*			* Includes Medicare Part D prescription drug coverage.		
<b>Note:</b> This plan is available in select counties in your state, as shown in the enclosed Summary of Benefits. <b>You do not pay any premium for this plan.</b>					
Last Name		First Name		MI	Mr. Mrs. Ms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Birth Date (mm/dd/yyyy)					
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Phone No. ( ) ( )	Alternate Phone No. ( ) ( )	E-Mail Address		County
Permanent Residence: Street Address (cannot use P.O. Box)			City	State	ZIP Code _ _ _ _ _ + _ _ _ _ _
Mailing/Billing Address (only if different from address above)			City	State	ZIP Code _ _ _ _ _ + _ _ _ _ _
<b>Section 2: Please provide your Medicare Insurance information:</b>					
Please take out your Medicare card to complete this section. • Please fill in the blanks at right so they match your red, white and blue Medicare card. <b>-or-</b> • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.  <b>You must have both Medicare Part A and Part B to join a Medicare Advantage plan. →</b>					
			Name _____		
			Medicare Claim Number _____		Sex _____
			Is Entitled To:		Effective Date:
			<b>Hospital (Part A)</b> _____		
<b>Medical (Part B)</b> _____					

A health plan with a Medicare contract.

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al numero telefónico que se muestra en el material adjunto. M0013\_08\_014 07/2007

M0013\_10\_038\_H0564\_006\_047  
09/11/2009

<i>Office Use Only:</i> Date Stamp
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CA

**Section 3: Please choose a Primary Care Physician (PCP) from the plan's Provider Directory.  
Write your choice below.**

Provider name \_\_\_\_\_

PCP ID # (see directory.) \_\_\_\_\_

Provider address \_\_\_\_\_

New physician for you?  YES  NO

\_\_\_\_\_  
\_\_\_\_\_

If enrolling in an Independent Practice Association (IPA) *or* a Participating Medical Group (PMG) instead of a PCP, please provide code here:   .

**Section 4: Paying Your Plan Premium**

***If you are enrolling in a plan without any premium:*** If the plan includes Medicare Part D prescription drug coverage and 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.

**Note:** People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

**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:  Checking: Enclose a VOIDED check

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.)

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 up to the date withholding begins.)

**Section 5: Please Read and Answer These Important 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. 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, in addition to the plan you are enrolling in? .....  Yes  No

*Section 5 continues on next page.*

**Section 5: Please Read and Answer These Important Questions: (continued)**

If “Yes,” please list the name(s) of your other coverage and your identification (ID) number(s) for this coverage below. Name of other coverage \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

3. Are you a resident in a long-term care facility, such as a nursing home?.....  Yes  No

If “Yes,” please provide the following information: Admission Date \_\_\_\_\_

Name of Facility \_\_\_\_\_ Facility Phone No. (\_\_\_\_) \_\_\_\_\_

Address of Facility \_\_\_\_\_

Street Address City State ZIP Code

4. Are you enrolled in your State Medicaid program?.....  Yes  No

If “Yes,” please provide your Medicaid number: \_\_\_\_\_ and Effective date: \_\_\_\_\_

5. Do you or your spouse work?.....  Yes  No

**Certain** materials for your plan are available, *upon request*, in large print and **might** be available in Spanish. Check here if you would prefer to receive any of those materials in:  Spanish or  large print. Then, to request certain materials in large print or to find out if materials for your plan are available in Spanish, please call the Prospective Members’ toll-free regular number, or TTY number, shown at the end of Section 1 of the enclosed Summary of Benefits. Our office hours are provided with the phone numbers.

**Section 6: Please Read This Important Information.**

**If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this plan.** 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 isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Section 7: Attestation of Eligibility for an Enrollment Period**

**Typically, you may enroll in a Medicare Advantage (MA) Plan only during the Annual 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) between January 1 and March 31 of each year, as long as you don’t add or drop 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 new to Medicare. (ICEP)  
Eligibility Date: \_\_\_\_\_  
Mo. Day Year

I recently moved outside of the service area for my current Medicare prescription drug plan. (SEP) Date of move: \_\_\_\_\_  
Mo. Day Year

I recently moved and this plan is a new option for me. (SEP)  
Date of move: \_\_\_\_\_  
Mo. Day Year

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

I get extra help to pay for Medicare prescription drug coverage. (SEP)

**Section 7 continues on next page.**

**Section 7: Attestation of Eligibility for an Enrollment Period (continued)**

- I no longer qualify for extra help paying for my Medicare prescription drug coverage. (SEP) I stopped receiving extra help on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year
- I will move into, now live in or recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP) Date of move: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year
- I recently left a PACE program (Program of All-inclusive Care for the Elderly) on date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (SEP)  
Mo. Day Year
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). (SEP) I lost my drug coverage on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year

- I am leaving employer or union coverage (SEP) on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year
- I belong to a pharmacy assistance program provided by my state. (SEP)
- I recently returned to the United States after living permanently outside of the U.S. (SEP) I returned to the U.S. on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year
- None of these statements applies to me.\*

*\* To see if you are eligible to enroll, please call the Prospective Members' toll-free regular number, or TTY number, shown at the end of Section 1 of the enclosed Summary of Benefits. Our office hours are provided with the phone numbers.*

**Section 8: Please Read and Sign Below:**

**By completing this enrollment application, I agree to the following:** The plan I am applying for 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 be in only 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 you 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 certain 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 Blue Cross (the Company) 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 will read the Evidence of Coverage (EOC) document from the Company when I get it to know which rules I must follow to get coverage with this Medicare Advantage Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that, beginning on the date Blue Cross Senior Secure (HMO) coverage begins, I must get all of my health care from Blue Cross Senior Secure (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Cross Senior Secure (HMO) and other services contained in my Blue Cross Senior Secure (HMO) Evidence of Coverage (EOC) document (also known as a member contract or subscriber agreement) will be covered as explained in my EOC. Without authorization, **neither Medicare nor Blue Cross Senior Secure (HMO) will pay for the services.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Company, he/she may be paid based on my enrollment in Blue Cross Senior Secure (HMO).

*Section 8 continues on next page.*

**Section 8: Please Read and Sign Below (continued):**

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Company 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.

*I understand that my signature* (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application 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 enrollment and 2) documentation of this authority is available upon request by the Company or by Medicare.

<b>Signature*</b>	<b>Today's Date:</b>
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*\*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 _____ + _____

***Office staff and Agents/Brokers: Please complete information on back page.***

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

**Internal Agents or External Agents/Brokers, please complete:** Coverage Effective Date: \_\_\_/\_\_\_/\_\_\_  
 ICEP/IEP    OEP    AEP    SEP (type): \_\_\_\_\_    Not Eligible

**Direct Sales Reps Only:** Complete if you assisted in enrollment.  
Print Name: \_\_\_\_\_ Tax ID (10 digits) or Agent Code (variable): | | | | | | | | | | | |  
Signature: \_\_\_\_\_ App. Received Date: \_\_\_/\_\_\_/\_\_\_

**External Agents/Brokers Only:** App. Rec'd: \_\_\_/\_\_\_/\_\_\_   *Please complete all lines below.*  
**Fax completed form to 1-805-713-5592.**  
I helped the applicant fill out this application:  
 Yes    No  
Please check the ID No. to use for commission payment:  
 Agent/Broker's Tax ID No.:  
| B | C | L | N | G | N | P | V | M | Z |  
 Agency Tax ID No.:  
| | | | | | | | | | | |  
**External Agent/Broker's**  
Signature \_\_\_\_\_  
Date \_\_\_\_\_

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.: (   ) 818-654-4548  
Fax No.: (   ) 818-776-9865  
E-Mail Address: OLEG@ASKOLEG.COM

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