

Blue MedicareRx (PDP) Medicare Prescription Drug Plan Individual Enrollment Form – 2011



Be sure to complete the entire enrollment form. Then, mail the completed form to

OLEG SKURSKIY 18375 VENTURA BLVD # 226 TARZANA, CA 91356 OR BY FAX 818-776-9865

Please contact Blue Cross and Blue Shield of Georgia if you need information in another language or format (Braille).

To enroll in Blue MedicareRx (PDP), please provide the following information:

Please check which plan you want to enroll in:

- Blue MedicareRx Standard (PDP) \$30.20 per month
- Blue MedicareRx Plus (PDP) \$54.50 per month
- Blue MedicareRx Premier (PDP) \$94.80 per month

Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
------------------	-------------------	-----------------------	---

Birth date (___/___/___) (M M / D D / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ()	Alternate phone number ()
--	---	-----------------------------------	--

Permanent residence street address (P.O. box is not allowed.)

City	State	ZIP code
------	-------	----------

Mailing address (only if different from your permanent residence address)

Street address	City	State	ZIP code
----------------	------	-------	----------

E-mail address

Please provide your Medicare insurance information.

Please take out your red, white and blue Medicare card to complete this section.

- Please fill in these blanks so they match your Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B or both to join a Medicare prescription drug plan.

MEDICARE		HEALTH INSURANCE
SAMPLE ONLY		
Name _____		
Medicare Claim Number	Sex ____	
_____ - _____ - _____		
Is Entitled To	Effective Date	
HOSPITAL (Part A)	_____	
MEDICAL (Part B)	_____	

Applicant Complete: Name _____ and Medicare ID number _____

Paying your plan premium

You can pay your monthly plan premium by mail or electronic funds transfer (EFT) each month. You also can choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your 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 also can apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name _____

Bank routing number _____

Bank account number _____

Account type Checking Savings

Automatic deduction from your monthly Social Security benefit check. (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 point withholding begins.)

Please read and answer these important questions:

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 your Blue MedicareRx (PDP)? Yes No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage ID number for this coverage Group number for this coverage

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 (number and street) and phone number of institution _____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

_____ Large print

Please contact Blue Cross and Blue Shield of Georgia at **1-866-892-5331** if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-241-6894**.

STOP

Please read this important information.

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have Part D prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Blue MedicareRx (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. 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 MedicareRx (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue MedicareRx (PDP). 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.

Typically, you may enroll in a Medicare Prescription Drug Plan during the annual enrollment period between November 15 and December 31 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement 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 new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get Extra Help paying for Medicare prescription drug coverage.
- I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date) _____.
- I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- None of these statements applies to me.*

*Please contact Blue Cross and Blue Shield of Georgia at **1-866-892-5331** (TTY users should call **1-800-241-6894**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week.

Please read and sign below.

By completing this enrollment application, I agree to the following:

Blue MedicareRx (PDP) is a Medicare Part D Drug Plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare. 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 automatically will end my enrollment in another Medicare health plan or prescription drug plan. If I am currently in a Medicare Prescription Drug Plan, my enrollment in this plan will end my enrollment in my current 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 (for example, November 15 – December 31 of every year), or under certain special circumstances.

Blue MedicareRx (PDP) serves a specific service area. If I move out of the area that Blue MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Blue MedicareRx (PDP) network pharmacies. Once I am a member of Blue MedicareRx (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross and Blue Shield of Georgia when I get it to know which rules I must follow to get coverage with this Medicare Prescription Drug Plan. I understand that people with Medicare usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Cross and Blue Shield of Georgia, he/she may be paid based on my enrollment in Blue MedicareRx (PDP).

Release of Information: By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross and Blue Shield of Georgia will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross and Blue Shield of Georgia will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which 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. 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 Blue Cross and Blue Shield of Georgia or by Medicare.

Signature _____	Today's date _____
------------------------	---------------------------

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number (____) _____ - _____

Relationship to Enrollee _____

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 NIPR# AEP SEP (type): _____ Not eligible

1. Was this an individual face-to-face appointment? Yes No (Do not proceed.)

2. If this was an individual face-to-face appointment, how was a scope of appointment (SOA) collected?
 Paper
 Recorded call (voice vault confirmation number _____)

3. Was the SOA signed on the same day as the appointment? Yes No (Do not proceed.)

4. If yes, please indicate the best reason below:

Appointment was requested at the end of the month for following month enrollment

Customer walk-in

Request for individual appointment immediately following a seminar sales event

Next day appointment

Other _____

Direct sales reps only: Complete if you assisted in enrollment.

Print name _____

Tax identification number (10 digits) or agent code (variable) |__|__|__|__|__|__|__|__|__|__|

Signature _____ Application received date ____/____/____

<p>External agents/brokers only: application received ____/____/____</p> <p>I helped the applicant fill out this application <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Please check the identification number to use for commission payment:</i></p> <p>Agent/broker's tax identification number 18159 __ __ __ __ __ __ __ __ __ __ </p> <p>Agency tax identification number 18159 __ __ __ __ __ __ __ __ __ __ </p>	<p>Please complete all lines below.</p> <p>Agent/broker's printed name OLEG SKURSKIY</p> <p>Agency name _____</p> <p style="text-align: center;">18375 Ventura Blvd # 226</p> <p>Street address _____</p> <p style="text-align: center;">Tarzana, CA 91356</p> <p>City _____ State _____ ZIP code _____</p> <p>Phone number (818) 654-4548</p> <p>Fax number (818) 776 9865</p> <p>E-mail address OLEG@ASKOLEG.COM</p>
<p>External agent/broker's</p> <p>Signature _____</p>	

Page 6 of 7

Applicant Complete: Name _____ and Medicare ID number _____

A Medicare-approved Part D sponsor.

Anthem Insurance Companies Inc. (AICI) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer to offer Medicare Prescription Drug Plans (PDPs) noted above or herein. AICI is the state-licensed, risk-bearing entity offering these plans. AICI has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs available in this region.

Blue Cross and Blue Shield of Georgia, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Page 7 of 7

Applicant Complete: Name _____ and Medicare ID number _____