

3 Easy Steps... Enrolling...to Blue Cross MedicareRX

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK.

Be sure you follow the instructions on the application carefully.

1. Print all pages of the application including instructions.
2. Complete all questions.

If you have any questions, or you are not sure how to answer a question, simply contact us:
Tel. (818) 987-5000 fax: (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT -

1. I would like to deduct from my Social Security Administration benefit check.
2. I would like to deduct from my checking account(complete "Optional Monthly Checking Account Deduction Authorization" form to page 4).
3. I would like to receive a premium bill and mail my check to Freedom Blue each month.

Step 3

SEND THE COMPLETED APPLICATION TO:

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

Or Fax the complete : 1-818-776-9865

We will be in contact with you upon receipt of your completed application.
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 us:

Oleg Skurskiy

Authorized Independent Agent

Tel.: 1-818-987-5000

Fax: 1-818-776-9865

oleg@askoleg.com

Thank you for choosing...



Medicare Prescription Drug Plan Individual Enrollment Form



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							

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 \$20.04					Monthly Premium \$28.56					Monthly Premium \$35.29				

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 can help.

Step 5: Please select your plan premium payment option.

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail or automatic withdrawal from your bank account. If you choose to make monthly payment by automatic withdrawal from your bank account, please complete the enclosed Automatic Payment Option form. Generally you must stay with the option you choose for the rest of the year.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the difference, if there is any, deducted from your monthly check.

Would you like the premium for this prescription drug plan deducted from your SSA monthly benefit check? **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 read and sign below.

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 users should call 1-877-486-2048.

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. I will read the Evidence of Coverage document from Blue Cross MedicareRx when I receive it to know which 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.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 MedicareRx or by Medicare.

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

**If you are the authorized representative, you must provide the following information:*

Name _____ Address _____

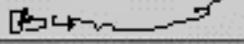
Phone number _____ Relationship to Enrollee _____

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

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

Medicare Prescription Drug Plan Use Only: Plan ID # _____

Effective Date of Coverage _____ IEP _____ AEP _____ SEP (type) _____

Agent Signature**  _____ Agent Number **BCLNGNPVMZ**

Broker Signature** _____ Code Number _____

I have assisted the applicant in filling out this application. **Yes **No**



Anthem Insurance Companies, Inc (AICI) is the legal entity under contract with the Centers for Medicare and Medicaid Services (CMS) authorized to offer the applicable Medicare Prescription Drug (Part D) plans and services in this region.

AICI is the legal entity licensed under applicable state law or under a federal waiver program that is authorized to offer these Part D plans. AICI has partnered with its affiliated local companies to provide various administrative and management services for these Part D plan(s).

Blue Cross of California is an Independent Licensee of the Blue Cross Association (BCA).

The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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Automatic Payment Option Authorization Form

Completed form should be mailed to:

Blue Cross of California
P.O. Box 9282
Oxnard, CA 93031

I hereby authorize **Blue Cross of California**, to initiate debit entries of premiums or any other related payments on my behalf and credit entries to my account indicated below, and the financial institution named below to debit/credit the same to such account.

Enrollment type <input type="checkbox"/> New <input type="checkbox"/> Revised		Requested effective date	
Financial Institution Information			
Bank Account type <input type="checkbox"/> Checking			
Financial Institution name			
Address	City	State	ZIP code
Bank Account no.	Bank ABA no.		
PLEASE ATTACH A BLANK, VOIDED CHECK FOR CHECKING ACCOUNT DEDUCTION.			
Customer Information			
Last name	First name	MI	
Blue Cross of California identification no.			
Home Address	City	State	ZIP code
Contact person name		Phone no.	

This authorization is to remain in full force and effect until **Blue Cross of California** and the above-named Financial Institution have received written notification simultaneously from me of its termination in such manner as **Blue Cross of California** and the above-named Financial Institution have a reasonable opportunity to act on it. **This form is valid for 60 days. If automatic draft from your bank is not established by that time, a new authorization form will be required.**

Printed name	Authorized Signature on this account	Date
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