Anthem MediBlue (HMO)

Individual Enrollment Request Form — 2017

Be sure to complete the entire enrollment form. Then, **mail** the completed form to **P.O. Box 659404 San Antonio TX, 78265-9863** ***or*** **fax** the completed form to **1-877-391-3877**. You can also enroll online at **www.anthem.com/ca/shop.** ***Note:*** Your agent/broker may provide different instructions.

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

Please check which plan you want to enroll in.

To add an Optional Supplemental Benefits (OSB) Package, check only one box from the options directly below the medical plan you selected.

☐ **Anthem MediBlue Plus (HMO)**
$0.00 per month

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

☐ **Dental and Vision Package**
$30.00 per month**

☐ **Enhanced Dental and Vision Package**
$37.00 per month**

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

Last name	**First name**	**MI**	☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**

Birthdate (MM/DD/YYYY)	**Sex** ☐ M ☐ F	**Home phone number**	**Alternate phone number**

Permanent residence street address (P.O. Box is not allowed.)			
City	State	ZIP code	County

Mailing address (only if different from your permanent residence address)		
City	State	ZIP code

Applicant Complete: Name _____ and Medicare Claim Number _____

White - agent copy; Yellow - member copy

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 and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Claim Number Sex ____

_____

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying your plan premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or electronic funds transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. (Note that direct bills will continue until EFT or SSA/RRB forms have been processed.)

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 choose one of the options below:

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) 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:** Must enclose a **VOIDED check**. ☐ **Savings:** Must enclose letter from financial institution with account information.

2) Please complete the following information for your account

Account holder name _____ Account number _____

Bank routing number _____ Bank name _____

(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.

Applicant Complete: Name _____ and Medicare Claim Number _____

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.** (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. **Do you have end-stage renal disease (ESRD)?** ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. **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 your current prescription drug coverage be ending? ☐ Yes ☐ No ☐ N/A

Will you continue to have other prescription drug coverage? ☐ Yes ☐ No ☐ N/A

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

Dates Covered: **Start** ___ ___ _____ **End** ___ ___ _____ Name of other coverage _____

ID # for this coverage _____ Group # for this coverage _____

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:

Name of institution _____

Address _____

City _____ State _____ ZIP code _____ Phone number _____

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

If "yes," please provide your Medicaid number _____

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

6. **Please choose the name of a primary care physician (PCP).** If you do not choose a PCP, one will be selected for you.

PCP Identification # (as shown in the Provider directory) _____

PCP name _____

PCP address _____

City _____ State _____ ZIP code _____

New physician for you? ☐ Yes ☐ No

Applicant Complete: Name _____ and Medicare Claim Number _____

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

☐ Spanish

☐ Braille, Audio Tape, Large Print or Voice-Enabled PDFs

Please contact Anthem MediBlue (HMO) at **1-888-230-7338** 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., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. TTY users should call **711**.

STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining Anthem Blue Cross could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Anthem Blue Cross. 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 Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year. Additionally, there are exceptions—i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs)—that may allow you to enroll in a Medicare Advantage 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.

NOTE: You must select at least one of the options below.

☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)

☐ I am new to Medicare. (IEP/ICEP)

☐ I am turning 65 and not new to Medicare. (IEP2)

☐ 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) _____ . (SEP)

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

☐ I get Extra Help paying for Medicare prescription drug coverage. (SEP)

☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date) _____ . (SEP)

☐ 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) _____ . (SEP)

☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____ . (SEP)

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ . (SEP)

☐ I am leaving employer or union coverage on (insert date) _____ . (SEP)

☐ I belong to a pharmacy assistance program provided by my state. (SEP)

Applicant Complete: Name _____ and Medicare Claim Number _____

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ . (SEP)

☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____ . (SEP)

☐ I was recently released from incarceration. I was released on (insert date) _____ . (SEP)

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ . (SEP)

☐ Other* _____

*Please contact Anthem Blue Cross at **1-888-230-7338.** Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30, (TTY users should call **711**) to see if you are eligible to enroll.

Email Preferences

Email is the fastest, easiest way to get important information about your plan – and some fun extras, too! Please provide a valid email address below:

Member's email _____

By giving my email address, I agree to receive email about my benefits, health programs and other plan services. I understand I may change my email preferences at any time by logging into my member profile at www.anthem.com/ca/shop or calling Customer Service.

***Agent/Broker*: For the email address entry above, only use member email addresses.**

Get important plan documents – fast – with e-delivery. Check the box next to each item you wish to receive by email, instead of postal mail:

☐ I agree to receive my **Welcome Kit** by email. This includes my first year *Evidence of Coverage, List of Covered Drugs (Formulary)*, tips for finding and ordering a Provider and Pharmacy Directory and other helpful plan information.

☐ I agree to receive my **Annual Notice of Changes** by email. This notice comes every year with my new *Evidence of Coverage*, *List of Covered Drugs (Formulary)*, and tips for finding and ordering a Provider and Pharmacy Directory.

Please read and sign in the "Applicant signature" box on the next page.

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

Anthem MediBlue (HMO) 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 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. I understand that if I have had a prior break in creditable prescription drug coverage (as good as Medicare's), or leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes

Applicant Complete: Name _____ and Medicare Claim Number _____

only at certain times of the year when an enrollment period is available (for example, October 15 – December 7 of every year), or under certain special circumstances.

Anthem MediBlue (HMO) serves a specific service area. If I move out of the area that Anthem Blue Cross 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 Anthem MediBlue (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Anthem Blue Cross 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 usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Anthem Blue Cross coverage begins, I must get all of my health care from Anthem Blue Cross participating providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem Blue Cross and other services contained in my Anthem MediBlue (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ANTHEM BLUE CROSS 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 Anthem Blue Cross, he/she may be paid based on my enrollment in Anthem MediBlue (HMO).

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

Signature Required to process your application.

Applicant signature X	**Today's date**
Desired plan effective date:	

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name		
Address		
City	**State**	**ZIP code**
Phone Number	**Relationship to Enrollee**	

Applicant Complete: Name _____ and Medicare Claim Number _____

Applicant: Please do not complete the following sections.
Agent/Broker: **Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.**

Coverage effective date _____ PLAN ID #: _____

☐ IEP/ICEP ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☒ No

Was this an individual face-to-face appointment? ☒ No ☐ Yes (if yes, how was a scope of appointment (SOA) collected? ☐ Paper ☐ Recorded call (voice recording ID) _____

Print name JAMES BARRICKS

Writing Agent TIN (10 digits)/Agent Code 0632872258S

Agency TIN (10 digits) or Agency Code 0632872258S

Agency Name JAMES BARRICKS

Street address 276 N EL CAMINO REAL 6

City OCEANSIDE State CA ZIP code 92058

Phone 760-433-0300 Fax 760-433-0304

Email INSURE@BARRICKSINSURANCE.COM

Signature _____ Application received date _____

Anthem Blue Cross is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

This information is available for free in other languages. Please call our Customer Service number at **1-888-230-7338** (TTY: **711**). Our office hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

Esta información está disponible sin cargo en otros idiomas. Por favor llame a nuestro número de Servicio al Cliente al **1-888-230-7338** (TTY: **711**), de 8 a. m. a 8 p. m., los 7 días de la semana (excepto los días feriados) desde el 1° de octubre hasta el 14 de febrero, y de 8 a. m. a 8 p. m., de lunes a viernes (excepto los días feriados) del 15 de febrero hasta el 30 de septiembre.

The provider network may change at any time. You will receive notice when necessary.

Applicant Complete: Name _____ and Medicare Claim Number _____