Blue Cross MedicareRx℠ (PDP)

Anthem Blue Cross

Medicare Prescription Drug Plan Individual Enrollment Form — 2010

Be sure to complete the entire enrollment form. Then, **mail** the completed form to: Enrollment Processing Center, P.O. Box 1080, North Haven, CT 06473-5180 ***or*** **fax** the completed form to: 1-888-884-5736.
Note: Your agent/broker may provide different instructions.

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

Section 1: To enroll in Blue Cross MedicareRx (PDP), please provide the following information *(please print clearly):*

Please check which plan you want to enroll in:

Plan Name:	☐ Blue Cross MedicareRx Standard (PDP)	☐ Blue Cross MedicareRx Plus (PDP)	☐ Blue Cross MedicareRx Gold (PDP)
Monthly Premium:	$28.40	$42.10	$78.50

Last Name	First Name	M I	Mr. ☐ Mrs. ☐ Ms. ☐	Birth Date (mm/dd/yyyy)

Sex ☐M ☐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 __ __ __ __ __ + __ __ __ __

Section 2: Please provide your Medicare Insurance information:

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.

-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

Name _____

Medicare Claim Number Sex ____

__ __ __ - __ __ - __ __ __ __

Is Entitled To: Effective Date:

Hospital (Part A) _____

Medical (Part B) _____

Section 3: Paying Your Plan Premium

You can pay your monthly plan premium by mail or by automatic bank account deduction. You might also be able to pay your premium by automatic deduction from your Social Security benefit check each month *(see next page)*.

Note: People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment

Section 3 continues on next page.

A Medicare-approved Part D sponsor.

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. C0003_08_008 07/2007

Office Use Only: Date Stamp

Section 3: Paying Your Plan Premium *(continued)*

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.**

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. Because you might be responsible for paying part of your premium, you must choose a premium payment option. We must receive payment for any amount that Medicare doesn't cover.

Please choose one of the payment options below: *(If no option is chosen, you will receive a monthly bill for the amount due.)*

☐ Send me a bill each month.

☐ Deduct my premium 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.

☐ Deduct my premium 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 4: 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 (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 _____ 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:

Name of Facility _____

Address and Phone No. of Facility _____ / (___) _____

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 5: Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period (AEP) between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period — you may be newly eligible for Medicare (in your Initial Enrollment Period, or IEP), or you may be eligible for a

Section 5 continues on next page.

Section 5: Attestation of Eligibility for an Enrollment Period *(continued)*

Special Enrollment Period (SEP).

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 Enrollment Period from November 15 to December 31. (AEP)
- ☐ I am new to Medicare. (IEP)
  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 paying for Medicare prescription drug coverage. (SEP)
- ☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage. (SEP)
- ☐ I live in or recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)
- ☐ I recently left a PACE program (Program of All-inclusive Care for the Elderly). (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). (SEP)
- ☐ 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 am eligible to disenroll from my Medicare Advantage plan and enroll in a Part D plan during an MA Open Enrollment Period or during a trial period. (SEP) Beginning and end dates of my eligibility period:
  _____ /_____
- ☐ 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 6: 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 Cross 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 Cross MedicareRx (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Section 7: Please Read and Sign Below:

By completing this enrollment application, I agree to the following: The plan I am applying for 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. Therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Anthem Blue Cross Life and Health Insurance Company (the Company) of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare

Section 7 continues on next page.

Section 7: Please Read and Sign Below *(continued)*:

prescription drug plan at a time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in this plan will end my enrollment in my current plan. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for 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 the Company 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 Cross MedicareRx (PDP) network pharmacies. 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 document from the Company when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug 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, in the future.

Blue Cross MedicareRx Gold (PDP) Plan Members Only: By joining this plan, I confirm that I am not getting any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) to buy medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage Plan or Medicare Prescription Drug Plan.

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 MedicareRx (PDP). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options and medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare prescription drug 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 State law 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.

Signature*	**Today's Date:**

**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 _ _ _ _ _ + _ _ _ _

Agents and Brokers: Please fill out the section on next page.

 Mandatory: Applicant's Name _____ & Medicare ID#_____

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: ____/____/_____

☐ IEP ☐ 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: ___/___/___

Fax* completed form to *1-805-713-6125.

I helped the applicant complete this form:

☐ Yes ☒ No

Please check the ID No. to use for commission payment:

☒ Agent/Broker's Tax ID No.: |063287258S|

☒ Agency Tax ID No.: |063287258S|

External Agent/Broker's

Signature _____

Date _____

Please complete all lines below.

Agent/Broker's Printed Name: JAMES BARRICKS

Agency Name: _____

Address: 13900 NW PASSAGE #302

Street Address

MARINA DEL REY, CA 90292

City *State* *ZIP Code*

Phone No.: ( ) 310-827-7286

Fax No.: ( ) 310-827-0256

E-Mail Address: insure@barricksinsurance.com

Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. Anthem is the state-licensed, risk-bearing entity offering these plans. Anthem 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.