Anthem Blue Cross MedicareRx (PDP)

Medicare Prescription Drug Plan
Individual Enrollment Request Form — 2019

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 **https://shop.anthem.com/medicare/ca.** ***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).

To enroll in Anthem Blue Cross MedicareRx (PDP), please provide the following information.			
☐ **Anthem Blue Cross MedicareRx Standard (PDP) $116.90 per month**		☐ **Anthem Blue Cross MedicareRx Plus (PDP) $113.10 per month**	
Last name	**First name**		**MI**
Birthdate (MM/DD/YYYY)	**Gender** ☐ 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	

Please provide your Medicare insurance information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): ____________________ Medicare Number: ____________________ Is Entitled To: Effective Date: HOSPITAL (Part A) ____________________ MEDICAL (Part B) ____________________ You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

enrollment form

Applicant Complete: Name ____________________ and Medicare Number ____________

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or electronic funds transfer (EFT) each month. You also can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board (RRB) benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Anthem Blue Cross.

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 won't have a 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 and 2 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.)

I authorize the bank above to deduct my monthly premiums

☐ **Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

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

enrollment form

Applicant Complete: Name ________________________________ and Medicare Number __________________

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 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 ____________________
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 ____ City ______________________ State ______ ZIP code ______________ Phone number _________________
Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format: ☐ Spanish Assistance for the visually impaired: ☐ Voice-Enabled (Audio) PDF ☐ Large Print Please contact Anthem Blue Cross MedicareRx (PDP) at **1-800-928-6201** if you need information in an accessible format or language other than what is listed above. TTY users should call **711**. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

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 Anthem Blue Cross 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 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 Prescription Drug Plan (PDP) 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) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Prescription Drug Plan outside of this period.

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.

Applicant Complete: Name ____________________________ and Medicare Number _________________

enrollment form

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)

☐ 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) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. (SEP)

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)__________. (SEP)

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)__________. (SEP)

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. (SEP)

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost 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)

☐ 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 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)

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)

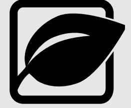
☐ Other* ____

*Please contact Anthem Blue Cross at **1-800-928-6201.** Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. (TTY users should call **711**) to see if you are eligible to enroll.

enrollment form

Applicant Complete: Name ____________________ and Medicare Number ____________________

Email Preferences



Email is the fastest, easiest way to get important information about your plan – and some fun extras, too! Please provide your email address below to sign up for our e-mail program.

Member's email @ ______________________________

By giving my email address, I agree to receive emails about my benefits, health programs and other plan services.
This includes getting digital versions of important, CMS-required plan documents such as the new member Welcome Kit, Annual Notice of Changes, and claim-specific Explanation of Benefits (EOBs).

I understand I can change my email preferences any time by logging into my member profile at **www.anthem.com/ca** or calling customer service.

☐ I prefer to get my Welcome Kit, Annual Notice of Changes, and EOB in the mail instead.

Please read and sign below.

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

Anthem Blue Cross MedicareRx (PDP) is a Medicare 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 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 – if I am currently in a Medicare prescription drug plan, my enrollment in Anthem Blue Cross will end that enrollment. 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 (October 15 – December 7), unless I qualify for certain special circumstances.

Anthem Blue Cross MedicareRx (PDP) 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. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Anthem Blue Cross network pharmacies. Once I am a member of Anthem Blue Cross 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 Anthem Blue Cross when I get it to know which rules I must follow to get coverage. 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 in the future. 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 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, 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 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 State law 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*:	

*Subject to Medicare election period guidelines

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 First Name	Last Name	
City	**State**	**ZIP code**
Phone Number	**Relationship to Enrollee**	

enrollment form

Applicant Complete: Name ______________________________ and Medicare 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 ☐ AEP ☐ OEP ☐ 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 ______________________________ | ______________________________
First Name Last Name

Writing Agent TIN (10 digits)/Agent Code___ ___ LMDLPKMMSZ___ ___ ___ ___

Agency TIN (10 digits) or Agency Code___ ___ ___ LMDLPKMMSZ___ ___ ___

Agency Name ____

Street address ____

City ______________________ State ____________ ZIP code ________

Phone ______________________ Fax ______________________

Email @ ______________________

Signature ____________________ Application received date ____________________

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health depends on contract renewal.

Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare & 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.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

ATENCIÓN: Si habla español, los servicios de asistencia lingüística están disponibles sin costo alguno para usted. Llame al 1-800-928-6201 (TTY: 711).

enrollment form

Applicant Complete: Name ______________________ and Medicare Number ______________