Medicoverage

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Medicoverage
FAX# 310.765.4136

Dear Medicoverage,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Medicoverage at 800.930.7956 to verify receipt of my application.

**I understand that Medicoverage will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend

I understand that the original, signed application and premium payment must still be mailed to Medicoverage. :

Medicoverage
Attn: New Enrollment
3379 Troy Drive

Los Angles, CA 90068

I will send the original, signed application and premium payment, as soon as I have been contacted by Medicoverage with confirmation that my application has been received by fax and reviewed for completeness.

Medicoverage

Application Instructions for Anthem Senior

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Medicoverage for review along with the completed application. If you do not have access to a fax machine, send the completed application to Medicoverage along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Anthem Senior** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Medicoverage
Attn: New Enrollment
3379 Troy Drive

Los Angles, CA 90068

Medicoverage will review your application for completeness and accuracy before we submit it to Anthem Senior for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800.930.7956 or e-mail us at info@medicoverage.com.

Norvax form #IN-1

Anthem Blue Cross
Health. Join In.

Anthem Blue Cross
Medicare Supplement Application — California

☐ New Enrollment ☐ Change to Enrollment

Send no money now! *For assistance please contact us at 888-211-9813 or contact your Anthem Blue Cross Insurance Agent. To be considered for coverage, you must live in California.*

Section A: Applicant Information (Please print and use black ink only.)

Last Name	First Name	MI	Sex ☐ M ☐ F	Age

Home Street Address	City	County	State	Zip Code

Social Security Number	Date of Birth	Home Phone Number	E-mail Address (optional)
__ __ __ | __ __ | __ __ __ __	__ __ | __ __ | __ __ __ __	( )	

Section B: Medicare Information (From your red, white and blue Medicare card.)

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____
MONTH/YEAR

Medical (Part B) Effective Date: _____
MONTH/YEAR

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)

EFFECTIVE DATE
07-01-2010
07-01-2010

Is a member of your household enrolled with us in a Medicare Supplement Plan? ☐ Yes ☐ No
If "Yes," you may be eligible for a discount* on your premium. Please provide the following information for that household member:

Name _____ Medicare Claim Number _____

Anthem Blue Cross Medicare Supplement Identification Number _____

*See the Outline of Coverage - Premium Information page for details.

Section C: Plan Chosen (Check only one plan under 1 or 2 below).

1. Are you age 65 or over OR turning 65 in the next 3 months? ☐ Yes ☐ No
If "yes," the following plan(s) are available to you:

Medicare Supplement: ☐ Plan A ☐ Plan F ☐ High Deductible Plan F ☐ Plan G ☐ Plan N

2. Are you under age 65 and eligible for Medicare due to a disability? ☐ Yes ☐ No

If "yes," only the following plan(s)* are available to you:

☐ Plan A ☐ Plan F

**Please note that individuals who have been diagnosed with End Stage Renal Disease do not qualify for either of these plans.*

Section D: Effective Date

Your effective date will be the *1st of the month after* we receive your completed application and it is approved and processed. Upon approval, your effective date cannot be changed. If you provide a future effective date at right, it cannot be more than *90 days* after the date we received your completed application or when first eligible for Medicare. **Note:** Effective date of coverage cannot be prior to your Medicare effective date.

If your existing coverage terminates on a date other than the end of the month, please indicate if you are requesting an initial enrollment date other than the 1st of the month. Initial Effective Date: __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

NOTE: After the initial effective date, your policy will move to a 1st of the month anniversary date.

If you want your coverage to start on a future date, enter date:

__ __ / 01 / __ __ __ __
M M D D Y Y Y Y

Section E: Billing Preference

How often do you prefer to be billed? Check one:

☐ Monthly* ☐ Quarterly ☐ Annually

**Monthly option is only available through Automatic Bank Draft. If you choose the Monthly option, please complete the enclosed Premium Payment Form.*

How do you want to pay your premiums?

☐ Automatic Bank Draft on the 6th day of the month, from ☐ Checking or ☐ Savings account
NOTE: *For Automatic Bank Draft, please complete the enclosed Premium Payment Form*.

☐ Credit card (*Please complete the enclosed Premium Payment Form*.)

☐ Direct Bill: Bills will be sent to your home address in Section A unless you provide a separate billing address below. Send bill to billing address below:

Name Street Address/PO Box City State ZIP Code

Section F: Preferred Language

As part of the California language assistance regulation (California Code of Regulations, Section 1300.67.04), Anthem Blue Cross is required to develop a demographic profile of its membership. The regulation specifically includes preferred spoken and written language as part of the information needed to develop a demographic profile. If you would like to assist us in our Language Assistance Program (part of our participation in the California language assistance regulation), please complete the two questions below.

Important: **Completing these questions is strictly voluntary. The information you provide will not be used in determining eligibility or insurability.**

To find the codes needed to answer the two questions below, please see the Optional Language Coding Sheet, enclosed with this enrollment form. For each question, find the appropriate code in the numbered section on the coding sheet and write it below.

Examples: If you prefer to speak ***Cantonese***, please use "W02" to complete Question 1. And if your preferred written language is ***Chinese***, please use "ZHO" for Question 2.

1. What is your preferred spoken language? section 1 - Code: _____
2. What is your preferred written language? section 2 - Code: _____

For each question, be sure to choose the code most appropriate for you. The codes that are **printed in bold** are more general categories. Only use a code in bold if none of the other categories apply to you.

Section G: Conditions of Application (Answer all questions.)

- Anthem Blue Cross ("the company") will not reject my application if (1) my coverage will start within 6 months of my 65th birthday, or (2) my coverage will start when I am age 65 or older and within 6 months of my Medicare Part B coverage start date, or (3) I am under age 65 and applying when first eligible or (4) I qualify for guaranteed-issue coverage for another reason. If my application is not received under one of those situations, the company has the right to reject my application. If the company rejects my application, I will be notified in writing. I understand and agree that if the company rejects my application, under no circumstances will any company benefits be payable.
- The company may request additional information, which may delay processing of this application. If the health care provider bills for this information, I understand that I may be responsible for the fee.

Please read the six statements below.

Important Statements

1. You do not need more than one Medicare Supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement policy.

4. If after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medi-Cal or Medicaid, for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling servcies may be obtained from the California Department of Aging.

(continued)

Section G: Conditions of Application *(continued)*

General Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

(Please answer all questions.)

To the best of your knowledge:

1. a. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
   b. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
   c. If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medi-Cal program? ☐ Yes ☐ No
   [Note to Applicant: If you are participating in a "Spend-Down Program" and have not met your Share of Cost, please answer "No" to this question.]

   If yes,
   a. Will Medi-Cal pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medi-Cal ***other than*** payments toward your Medicare Part B premium? ☐ Yes ☐ No

3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

      START ____/____/____ END ____/____/____

   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   c. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

4. a. Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
   b. If so, with what company, and what plan do you have?

      _____

   c. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union or individual plan) ☐ Yes ☐ No

   a. If so, with what company and what kind of policy? _____

   b. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

      START ____/____/____ END ____/____/____

Section H: Health History and Medical Provider Information (If this section applies to you, answer all questions.)

GUARANTEED ISSUE RIGHTS NOTICE: Before answering any Health History or Medical Information Questions, please read this important information regarding Medicare Supplement Guaranteed Issue rights.

You are not required to provide health information during a period of guaranteed issuance. You are not required to answer the Health History or Medical information questions in this application if you are entitled to a guaranteed issue Medicare Supplement Plan. If you qualify for enrollment on the basis of guaranteed issue, you will not be denied coverage.

We require applicants to sign an authorization requested by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to use or obtain medical information; however, if you qualify for Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan, you will not be required to sign that authorization.

Please refer to the **Medicare Supplement Guaranteed Issue Guideline** provided with this application to determine if you qualify for Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan.

If you think you qualify for guaranteed acceptance into an Anthem Blue Cross Medicare Supplement Plan, write the number of your qualifying situation, as described in the Guideline, in the Box below and sign where indicated.

I have read and I understand the Medicare Supplement Guaranteed Issue Guideline, which was provided to me with this application. I believe that I qualify for guaranteed acceptance based on situation number: ☐ I have attached proper documentation, if necessary, to validate my eligibility for guaranteed acceptance.

Signature:_____ Date:_____

You must already be enrolled in Medicare Parts A and B to apply for these plans.

If you do not qualify for enrollment on the basis of guaranteed issue, you must complete the questions below.

Note: If the answer to any of the following questions is "yes," you might not be eligible for coverage.

1. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility or other care facility, or do you need the assistance of a wheelchair for any daily activity? ☐ Yes ☐ No
2. Within the past two years, have you been hospitalized two or more times or been confined to a nursing home for a total of two weeks or longer? ☐ Yes ☐ No
3. Within in the past two years, have you been advised to have surgery that has not yet been done? ☐ Yes ☐ No
4. Within the past five years, have you been told you had, been consulted for treatment of, sought treatment for, had treatment recommended for, received treatment for, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for any of the following conditions:
   a. Heart conditions, including but not limited to, heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, peripheral vascular disease, heart rhythm disorders, transient ischemic attack (TIA) or stroke? ☐ Yes ☐ No
   b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder or other senility disorder? ☐ Yes ☐ No
   c. Any respiratory condition, including but not limited to, Chronic Obstructive Pulmonary Disease (COPD) or emphysema (excluding allergies and asthma)? ☐ Yes ☐ No
   d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, chronic kidney disease (including end-stage renal disease), kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, any organ transplant (except cornea), amputation or joint replacement due to disease? ☐ Yes ☐ No
5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No

(continued)

Section H: Health History and Medical Provider Information (If this section applies to you, answer all questions.) *(continued)*

If you are not taking any medications, please check here: ☐ I am not taking any medications.

If you answered "YES" to any of the questions above, or if you are taking any medications, give complete details (see the example below as a guideline). If additional space is needed, attach separate sheet.

Item #	Specific illness, injury, procedure, surgery, hospitalization or condition	Name of Medication and Dates of Use		Name, Address, Telephone (w/area code), and Fax for Doctor	Dates of illness, injury, procedure, surgery, hospitalization or condition	
					Begin	End/Current
Note: This row is an example of how to complete this section. Please begin with next row.						
4a	Congestive Heart Failure	Lanoxin		Dr. John Doe 10 High Street, Suite 45 Anywhere, US 19222 1-555-555-1000 (phone) 1-800-555-2000 (fax)	11/1999	7/2005
		1/2001	7/2005			

Name of Primary Care Physician: _____ Telephone (_____) _____

Address: _____

Section I: Authorizations and Agreements

I, the applicant or my authorized representative, have read and understand this Application in its entirety. I, the applicant or my authorized representative, have personally completed this Application. I understand and agree to the Replacement Notification provided with this Application and to the Conditions of Application and the Authorization and Agreements in this Application. If my Application is accepted, it will become part of the agreement between the company and myself.

I, the applicant or my authorized representative, acknowledge receipt of:

- "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," and
- the "Outline of Coverage."

I, the applicant or my authorized representative, understand that the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy or terms of any company coverage.

I, the applicant, am currently enrolled in an Anthem Blue Cross individual health policy and wish to cancel that policy when this Medicare Supplement Application is approved and I become enrolled.

Policy Number: _____

(continued)

Section I: Authorizations and Agreements *(continued)*

If your present Anthem Blue Cross coverage provides benefits for a spouse and/or dependents who are not eligible for Medicare, complete the following. This will enable us to offer them continuous coverage that is comparable to your current coverage.

Name:	Relationship:
DOB: __ __ / __ __ / __ __ __ __	SSN: __ __ __ | __ __ | __ __ __ __
Name:	Relationship:
DOB: __ __ / __ __ / __ __ __ __	SSN: __ __ __ | __ __ | __ __ __ __
Name:	Relationship:
DOB: __ __ / __ __ / __ __ __ __	SSN: __ __ __ | __ __ | __ __ __ __

I, the applicant or my authorized representative, acknowledge responsibility for any overdraft fees permitted by state law.

I, the applicant or my authorized representative, understand that there is a 6-month benefit waiting period for coverage of any condition for which I received medical treatment or advice within the 6 months prior to the effective date of this Medicare Supplement policy. I understand that the time I was covered under any other health insurance will be counted toward this 6-month benefit waiting period, if there is not a break in coverage greater than 63 days between the termination of the other coverage and the effective date of this Medicare Supplement policy.

I, the applicant or my authorized representative, understand that if I incur an illness or change in medical condition during the time between the date I sign this application and the effective date of coverage, I must notify Anthem Blue Cross in writing of any such illness or change, and such notice shall be a condition of my coverage. (This does not apply if I am applying during my open enrollment period or qualify for guaranteed-issue coverage for another reason.)

I, the applicant or my authorized representative, understand that Anthem Blue Cross may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement, although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross automatic debit process and will only occur each time I send a check to Anthem Blue Cross. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.

I, the applicant or my authorized representative, alone have responsibility for accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted. I understand that the company may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions regarding my past or present health conditions.

Conditioned Authorization to Use or Obtain Medical Information to Pay Claims

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex), but not including psychotherapy notes.

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

(continued)

Section I: Authorizations and Agreements *(continued)*

Entities or Persons Authorized to Receive: The company, its agents, employees, designees, or representatives, including my company agent or broker, for the purpose(s) described below.

Purpose of this Authorization: By signing this form, you will authorize us to use and/or disclose your PHI to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Effect of Declining: If I decide not to sign this authorization, you may decline to enroll me in our health plan. This PHI may be used or disclosed subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon termination of any company coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Anthem Blue Cross, PO Box 9063, Oxnard, CA 93031-9063

I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my PHI, as described in this authorization.

If the authorization is signed by a personal representative, on behalf of the individual, complete the following:

	X	
Print Applicant's Name	*Applicant's Signature*	*Date*

Name of the other person or persons authorized to receive my PHI:

Name of Authorized Person	*Relationship to Applicant*

X	
Applicant's Signature	*Date*

A photocopy of this authorization is as valid as the original, and I and my Anthem Blue Cross agent or broker are entitled to receive a copy of this form after I sign it.

Notice: California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining health insurance coverage.

Section J: Binding Arbitration

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

Signature (Required)

Applicant's Signature	*Date of Signature*

Section K: Policy or Certificate Issuance

Important: This Application will not be processed unless the applicant signs below. By signing below, you agree to the acknowledgments in Section I. Please do not cancel your present coverage, if any, until you receive documentation from Anthem Blue Cross, such as an ID card or written notification, showing that your Application has been approved.

To ensure timely processing, verify the following:

1) Complete, sign and date all sections as indicated by signature boxes.

2) If you want the convenience of automatic bank draft or credit card for payment purposes, be sure to complete the ***Premium Payment Form***.

Please mail the entire Application (including the Premium Payment Form) to the address below –

Are you working with an insurance agent? (No additional charges when working with your agent.)	Did you contact Anthem Blue Cross directly?
If yes, mail to:	If yes, mail to:
Anthem Blue Cross PO Box 9063 Oxnard, CA 93031-9063 OR Fax to: 805-375-0361	Enrollment Processing Center PO Box 5007 Middletown, NY 10940-9007 OR Fax to: 888-884-5736

Signature of Applicant, or Authorized Representative (if applicable)*	Date
X	X

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to application (such as a Power of Attorney).

SEND NO MONEY NOW – PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED AND YOU RECEIVE YOUR PREMIUM NOTICE.

Section L: Agent/Broker Information Only: If application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the application, if appropriate. *(Attach additional sheets if necessary.)*

Important: Before this form can be processed, the agent/broker's current health and life license must be on file. In addition, the agent/broker must be appointed with us.

Agency No.: _____ Agent/Broker No.: MLKLLRMSWY

(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name: Eric Scheinbaum Phone No. (800)930-7956

Fax No. (310)765-4136 E-mail address: info@medicoverage.com

Street Address 3379 Troy Drive

Los Angles CA

City State ZIP Code

Attestation - Please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this application by phone, e-mail or in person.

☐ I assisted the applicant in completing and/or submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Notice: If you state as an agent any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000).

Please list all health insurance policies you have issued to the applicant that are still in force and any other health insurance issued in the past 5 years that are no longer in force and submit with the application, as required:

_____ _____

Name of Policy Name of Insurance Company

Policy Date from: ___ / _____ _____

M M Y Y Y Y Street Address of Insurance Company

Policy Date to: ___ / _____ _____

M M Y Y Y Y City/State of Insurance Company

I have read and understand the application. I additionally certify that I have given the applicant the "Guide to Health Insurance for People with Medicare," the Medicare Supplement Guaranteed Issue Guideline and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

Agent/Broker's Signature: X _____ Date of Signature: X _____

Agent/Broker: Submit completed application to:

Anthem Blue Cross
PO Box 9063
Oxnard, CA 93031-9063
or Fax to 805-375-0361

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Anthem Blue Cross
PO Box 9063, Oxnard, CA 93031-9063

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
_____
☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

_____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

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Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Anthem Blue Cross
PO Box 9063, Oxnard, CA 93031-9063

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
_____
☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

_____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

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Medicare Supplement Guaranteed Issue Guideline

Important: Please note this Guide is only a summary, and is intended to help you identify the different situations that may qualify you for a Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan.

Listed below are situations in which a Medicare applicant/member has the right to purchase a Medigap policy. These rights are commonly called Guaranteed Issue (GI) rights. In these circumstances, acceptance into a Medicare Supplemental policy is guaranteed regardless of the applicant's medical condition(s).

Anthem Blue Cross offers certain Medicare Supplement plans on a Guaranteed Issue basis. The plans available may vary depending on the individual's Guaranteed Issue situation.

Situations

1. **Part B effective date:** You are eligible for Guaranteed Issue if you are (a) at least 65 years of age, or (b) if you are under age 65 and do not have End Stage Renal Disease; and you apply for an Anthem Blue Cross Medicare Supplement Plan prior to or during the six-month period beginning with the first day of the month of your Part B effective date. ***With your application, you must submit*** evidence that you have Medicare Parts A and B.
2. **Disabled and receiving Medicare benefits prior to your 65th birthday:** Upon your 65th birthday you will receive a 6-month Guaranteed Issue period beginning with the first of the month in which you reach age 65. ***With your application, you must submit*** evidence that you have Medicare Parts A and B.
3. **Termination of coverage or reduction of coverage under a group-sponsored health plan:** If you are receiving health care coverage through your group employer and you decide to terminate the group plan, or the benefits of the group plan are reduced, you are entitled to a 6-month Guaranteed Issue period beginning on the date of termination or benefit reduction. ***With your application, you must provide*** proof of disenrollment or benefit reduction.
4. **Medicare Advantage (MA) coverage ends due to the Plan leaving the program or area:** You have 123 days (60 days prior to the date of termination and no more than 63 days after the date of termination) to select a Medigap plan from any company in the area. ***With your application, you must provide*** proof of disenrollment.
5. **Termination of health care for military retiree or spouse or dependents due to military base closure, or if the base no longer offers services, or if you relocated:** If you are a Medicare-eligible military retiree or dependent and at least 65, you are entitled to a 6-month Guaranteed Issue period beginning the date you lost health care services at the military base. ***With your application, you must provide*** proof of termination of prior insurance.

(continued)

6. **Upon becoming eligible for Medicare benefits at age 65, you enrolled in a MA plan and then disenrolled within 12 months:** You are entitled to a Guaranteed Issue period of 63 days beginning with the date of disenrollment from the MA plan. ***With your application, you must provide*** proof of prior insurance.
7. **Disenroll from a Select, PACE or MA plan within 1 year of leaving a Medigap policy for the first time.** You are entitled to re-enroll in your original Medigap policy within 63 days of your disenrollment in one of these plans, beginning with the date of termination. This must be your first time enrolled in a Select, PACE, or MA plan. ***With your application, you must provide*** proof of prior insurance.
8. **Birthday Rule:** You are entitled to acceptance into equal or lesser value plans for 30 days beginning on your birthday. You must have a Medicare Supplement Plan and, ***with your application, you must provide*** proof of prior coverage.
9. **Leave your plan as a result of fraud committed by the plan:** You are entitled to a 63-day Guaranteed Issue period beginning with the latter of the date of termination or the fraud determination date. ***With your application, you must provide*** proof of prior coverage and provide a determination letter stating the plan was at fault.
10. **Your Anthem Blue Cross MA plan reduces benefits, increases the cost sharing amount, or discontinues a provider for other than good cause:** If any one of these events occurs, you are entitled to a Guaranteed Issue period of 63 days. ***With your application, you must provide*** proof of prior coverage.
11. **If you lost coverage because you moved out of the service area of your plan,** you are entitled to a Guaranteed Issue period for up to 6 months following the termination of your contract. ***With your application, you must provide*** proof, such as a letter from your prior carrier stating, "You will no longer have coverage due to moving out of the covered service area."
12. **If you had Medi-Cal or Medicare benefits and have lost eligibility for those benefits,** you are guaranteed acceptance into a Medicare Supplement plan, provided that you apply within 6 months of losing eligibility that you received from Medi-Cal or Medicaid. ***With your application, you must provide*** a copy of the notice of loss of eligibility that you received from Medi-Cal or Medicaid.

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Optional Language Coding Sheet

To answer the two questions in Section F of your enrollment form, please select the appropriate code in each section below. Then write the code on the line next to the appropriate question on your enrollment form. For example, if you prefer to speak ***Cantonese***, please complete Question 1 with code "W02." ("What is your preferred spoken language? section 1 — Code: ***W02***")

Important: *Completing these questions is strictly voluntary. The information you provide will not be used in determining eligibility or insurability.*

1. Preferred Spoken Language

American Indian ..... NAI	Iliko ..... ILO	Scottish ..... GLA
Arabic ..... ARA	Indonesian ..... IND	Sign Language, American ..... SGN
Aramaic ..... ARC	Irish ..... GLE	Sign Language, Other W07
Armenian ..... HYE	Italian ..... ITA	Spanish ..... SPA
Cambodian/Khmer W01	Japanese ..... JPN	Speech Loss ..... ZZS
Cantonese W02	Korean ..... KOR	Tagalog ..... TGL
Chinese ..... ZHO	Lao ..... LAO	Tahitian ..... TAH
English ..... ENG	Mandarin W05	Thai ..... THA
Farsi W04	MEIN W08	Turkish ..... TUR
French ..... FRA	Nigerian W06	Vietnamese ..... VIE
German ..... DEU	Persian ..... FAS	**Other Non-English W09**
Hawaiian ..... HAW	Polish ..... POL	**Undetermined ..... UND**
Hebrew ..... HEB	Portuguese ..... POR	**Decline to state W03**
Hearing loss ..... ZZH	Pushto ..... PUS	
Hindi ..... HIN	Russian ..... RUS	
Hmong ..... HMN	Samoan ..... SMO	

2. Preferred Written Language

American Indian ..... NAI	Hmong ..... HMN	Pushto ..... PUS
Arabic ..... ARA	Iliko ..... ILO	Russian ..... RUS
Aramaic ..... ARC	Indonesian ..... IND	Samoan ..... SMO
Armenian ..... HYE	Irish ..... GLE	Scottish ..... GLA
Cambodian W01	Italian ..... ITA	Spanish ..... SPA
Cantonese W02	Japanese ..... JPN	Tagalog ..... TGL
Chinese ..... ZHO	Korean ..... KOR	Tahitian ..... TAH
English ..... ENG	Lao ..... LAO	Thai ..... THA
Farsi W04	Mandarin W05	Turkish ..... TUR
French ..... FRA	MEIN W08	Vietnamese ..... VIE
German ..... DEU	Nigerian W06	**Other Non-English W09**
Hawaiian ..... HAW	Persian ..... FAS	**Undetermined ..... UND**
Hebrew ..... HEB	Polish ..... POL	**Decline to state W03**
Hindi ..... HIN	Portuguese ..... POR	

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Premium Payment Form

(Please Print Clearly)

Anthem Blue Cross
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Save $2 on Your Monthly Premium — Enroll in Automatic Bank Draft

If you sign up for monthly Automatic Bank Draft (sometimes referred to as Electronic Funds Transfer or EFT), we will pass the savings on to you. By eliminating a monthly bill, you save as well in time and postage. In addition, there's no need to worry about your premium if you are traveling or hospitalized.

Applicant's Full Name:_____ Date of Application: _____

Please Return this Form With Your Application.

Section 1. Amount of Premium

I understand that the initial premium for the coverage I have selected is $_____.
(If your application is accepted and the amount you indicated is less than or more than the actual premium amount, the difference will be reflected as a debit or a credit on the first bill you receive from Anthem Blue Cross (the Company) — provided that the amount is within our payment guidelines. If the amount is not within our guidelines, we will notify you.)

Section 2: Payment Method:

I am paying the initial premium by *(check only one option)*:

☐ Credit Card ☐ Debit Card

☐ Automatic bank account withdrawal

A. If Paying by Credit or Debit Card:

A credit/debit card can be used for the initial premium payment. If your application is accepted, you will be billed for future payments (unless you chose Annual Billing* on your Application) or you can sign up for monthly automatic bank withdrawal.

Note: *If you select Annual as your billing preference on your Application, we will charge your account for premium from your effective date through the end of the year.*

Authorization: *I authorize the Company to charge the credit/debit card indicated below for the amount specified in Section 1.*

Applicant's Signature:

X _____

Following is my credit/debit card information

Cardholder's Name (as shown on the credit/debit card):

_____

If Applicant is using the credit/debit card of another cardholder: By signing this form, Applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of Credit/Debit Card: ☐ VISA ☐ MasterCard

Credit Card Number: _____

Expiration Date *(month/year)*:_____/_____

Cardholder Billing Address: _____

_____

_____

B. If Paying by Monthly Automatic Bank Withdrawal:

Deduct premiums from the below account for *(check one)*:

☐ My first month payment only

☐ My first and ongoing payments

☐ My ongoing payments only (I am making my first payment by another method)

If you want to change your payment method later, please contact us.

Authorization and Signature(s): *I/we authorize the Company to make withdrawals in the amount of the then-current premium rate, based on the billing frequency indicated on my Application, from the:*

☐ **Checking Account:** ☐ Personal ☐ Business
☐ **Savings Account:** ☐ Personal ☐ Business

named below and I/we authorize the financial institution to charge such withdrawals to my/our account.

Provide the following bank account information**
Name(s) on Checking/Savings Account:

_____

_____

Name of Bank (or other Financial Institution):

_____

Financial Institution Routing No.:
(first 9 digits in lower left corner of check/deposit slip)

___ ___ ___ ___ ___ ___ ___ ___ ___

Account No.: _____

** *You may attach a check or savings account deposit slip from your bank, marked "VOID" in ink.*

C. Authorization:

This authorization remains in effect until the Company and the financial institution above receive notification from me or one of us (if a joint account) of its termination in such time and manner as to provide reasonable time to act on it, or the policy terminates.

Each person listed on the checking/savings account must sign here:

X _____

X _____