

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## **Step 1**

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department  
at: \_\_\_\_\_ fax: \_\_\_\_\_

## **Step 2**

**SELECT THE TYPE OF BILLING YOU WANT.**

## **Step 3**

**SEND THE COMPLETED APPLICATION TO:**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...



**Anthem Blue Cross Life and Health  
Insurance Company  
Freedom Blue<sup>SM</sup>**



**Medicare Advantage PPO Individual Enrollment Request Form – 2009**

**Be sure to complete all four pages of the enrollment form** and return it to:  
Enrollment Processing Center, P.O. Box 5007, Middletown, NY 10940-9007.

**Section 1: Please provide information about you. (Please print clearly.)**

Last Name		First Name			Middle Initial	
Permanent residence street address (cannot use P.O. Box)				City	County	
State	ZIP Code	Phone No. ( ) ( )	Alternate Phone No. ( ) ( )	Social Security No. (optional)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Mailing/Billing Address (if different from address above)			City	State	ZIP Code	

**Section 2: Benefit Plan Selection**

**Note to Applicant:** For information about the service areas and the premiums of the Medicare Advantage plans available to you, please refer to the Summary of Benefits enclosed with your enrollment materials.

**I wish to enroll in the plan checked here:**  Freedom Blue Plan I  
This plan includes Medicare Part D prescription drug coverage.

**Section 3: Please provide your Medicare Insurance information.**

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> <li>Please fill in the blanks at right so they match your red, white and blue Medicare card.</li> </ul> <p><b>-or-</b></p> <ul style="list-style-type: none"> <li>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p><b>You must have both Medicare Part A and Part B to join a Medicare Advantage plan.</b> →</p>	<table border="1" style="width: 100%;"> <tr> <td style="text-align: center;"><b>MEDICARE</b></td> <td style="text-align: center;"></td> <td style="text-align: center;"><b>HEALTH INSURANCE</b></td> </tr> <tr> <td colspan="3">Name _____</td> </tr> <tr> <td colspan="2">Medicare Claim Number _____</td> <td>Sex _____</td> </tr> <tr> <td colspan="3">_____ - _____ - _____</td> </tr> <tr> <td colspan="2">Is Entitled To:</td> <td>Effective Date:</td> </tr> <tr> <td colspan="2"><b>Hospital (Part A)</b></td> <td>_____</td> </tr> <tr> <td colspan="2"><b>Medical (Part B)</b></td> <td>_____</td> </tr> </table>	<b>MEDICARE</b>		<b>HEALTH INSURANCE</b>	Name _____			Medicare Claim Number _____		Sex _____	_____ - _____ - _____			Is Entitled To:		Effective Date:	<b>Hospital (Part A)</b>		_____	<b>Medical (Part B)</b>		_____
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<b>Medical (Part B)</b>		_____																				

**Section 4: Please indicate if you prefer information in another language or format.**

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:

In Spanish. (To see if materials in Spanish are available for your plan, please call Customer Service at the phone number shown in the enclosed Summary of Benefits.)

In large print

If you need more information about materials in a format other than shown above, call Customer Service at the phone number shown in the enclosed Summary of Benefits.

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al número telefónico que se muestra en el material adjunto. M0013\_08\_014 07/2007

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*Office Use Only:* Date Stamp

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M0013\_09\_039 09/2008

**Section 5: Paying Your Plan Premium.**

**If you are enrolling in a plan without any premium:** If we determine that you owe a late enrollment penalty for the Medicare Part D prescription drug portion of your plan, we need to know how you would prefer to pay it. Please choose one of the payment options in the checklist below.

**If you are enrolling in a plan with a monthly premium,** how would you like to pay future plan premiums? 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 Check each month (*see below*).

**Note:** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or some portion of your plan premium. However, because you might be responsible for paying part of your premium, you still must choose a premium payment option. We must receive payment for the amount that Medicare does not cover.

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

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

**Automatic Bank Account Deduction:** Deduct the amount 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.

**Automatic Social Security Deduction:** Deduct the amount 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 to the date withholding begins.*)

**Section 6: Please Answer the Following Questions:**

1. Do you have End Stage Renal Disease (ESRD)? .....  Yes  No  
Generally, if you answered "Yes," you are not eligible to enroll in this plan. However, if you answered "Yes" to this question but you no longer need regular dialysis or have had a successful kidney transplant, **please attach a note or records from your doctor** stating this.

2. Do you or your spouse work? .....  Yes  No

3. Are you enrolled in your State Medicaid program? .....  Yes  No  
If "Yes," please provide your Medicaid number: \_\_\_\_\_ and Effective date: \_\_\_\_\_

4. 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 Facility \_\_\_\_\_ Facility Phone no. (\_\_\_\_) \_\_\_\_\_ Admission Date \_\_\_\_\_

Address of Facility \_\_\_\_\_  
*Street address City State Zip code*

5. In addition to Freedom Blue, will you have other prescription drug coverage, such as *other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs?* . . .  Yes  No  
If "Yes," please list the name(s) of your other coverage and your identification (ID) number(s) for this coverage below.

Name of coverage \_\_\_\_\_ ID no. \_\_\_\_\_ Group no. \_\_\_\_\_

**Section 7: Important — Please read.**

**If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining this plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## Section 8: Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage (MA) Plan only during the Annual Open Enrollment Period (AEP) between November 15 and December 31 of each year. You can also join an MA plan during the MA Open Enrollment Period (MA-OEP) from January 1 to March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions — i.e., Initial Enrollment Period (ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in an MA 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.

- |   |   |
|---|---|
| <input type="checkbox"/> I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)                     | <input type="checkbox"/> I recently moved outside of the service area of my current plan. (SEP) Date of move: ____/____/____<br><small>Mo. Day Year</small> |
| <input type="checkbox"/> I am enrolling during the MA Open Enrollment Period from January 1 to March 31. (MA-OEP)                           | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). (SEP)                     |
| <input type="checkbox"/> I am newly eligible for Medicare. (ICEP)<br>Eligibility Date: ____/____/____<br><small>Mo. Day Year</small>        | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. (SEP)  |
| <input type="checkbox"/> I recently moved and this plan is a new option for me.   | <input type="checkbox"/> I receive extra help to pay for Medicare prescription drug coverage. (SEP)   |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. (SEP)                        | <input type="checkbox"/> I am no longer eligible for extra help to pay for my Medicare prescription drug coverage. (SEP)                                    |
| <input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)                            | <input type="checkbox"/> I am involuntarily losing coverage I had from an employer or union. (SEP) <i>Attach copy of coverage termination letter.</i>       |
| <input type="checkbox"/> I live in a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)               | <input type="checkbox"/> I am voluntarily leaving coverage I had from an employer or union. (SEP) <i>Attach copy of coverage termination letter.</i>        |
| <input type="checkbox"/> I recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP) | <input type="checkbox"/> None of these statements applies to me.*   |
| <input type="checkbox"/> I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP)                                      |   |

\* To see if you are eligible to enroll, please contact us at the telephone number for Prospective Members shown in the enclosed Summary of Benefits.

If you qualify for an SEP and want a future effective date, please request here: Mo. \_\_\_\_ / Day **01** / Year \_\_\_\_

## Section 9: Application Agreement **Important: Read this information before signing in Section 10 on next page.**

**By completing this enrollment application, I agree to the following:** Freedom Blue 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 only be in 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 plan or prescription drug plan. It is my responsibility to inform Anthem Blue Cross Life and Health Insurance Company (Anthem) of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 – December 31 of every year), or under 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 Anthem so I can disenroll and find a new plan in my new area. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I agree that the Evidence of Coverage (EOC) document governs the rules that I must follow to receive coverage in this Medicare Advantage Plan. When I receive the EOC document from Anthem, I will read it so I know the rules to follow. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. I understand that, beginning on the date Freedom Blue coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Freedom Blue provides reimbursement for all covered benefits, even if received out of network. Services authorized by Freedom Blue and other services contained in my Freedom Blue Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Freedom Blue will pay for the services.**

I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Anthem, he/she may be compensated based on my enrollment in Freedom Blue.

**Section 9 continues on next page.**

