

# 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: 818-654-4548 fax: 818-776-9865

## Step 2

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

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

Oleg Skurskiy  
18375 Ventura Blvd. # 226  
Tarzana, CA 91356

**Please make your check payable to: Anthem Blue Cross**

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: 818-654-4548**

Thank you for choosing...





# SENIOR ENROLLMENT APPLICATION

For Seniors with Medicare Parts A and B

Please complete entire application.

Application for a Plan to Supplement Medicare (*select one*)

- Blue Cross Senior Classic<sup>SM</sup> C     
  Blue Cross Senior Classic F     
  Blue Cross Senior Classic I  
 Blue Cross Senior Classic J     
  Standard Plan A

A two-party contract (Member and Spouse rate) is available for eligible couples, at their option. Both spouses must be age 65 or older, enrolled in both Parts A and B of Medicare, and apply for the same plan. If you and your spouse are applying for a two-party contract, please check this box: →  Yes

If yes, you and your spouse will each have to fill out your own application, list the other spouse's name and Social Security Number, and submit both applications together.

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Name of Your Spouse \_\_\_\_\_ Your Spouse's Social Security Number \_\_\_\_\_

Please enclose only one check for the applicable rate for the two of you.

## Section 1 – Applicant Information

This complete original application will be returned to you, for your records, along with your certificate, when you are enrolled.

**Please copy the information from your Medicare card here**

↓

NAME OF BENEFICIARY \_\_\_\_\_

CLAIM NUMBER \_\_\_\_\_ SEX \_\_\_\_\_

IS ENTITLED TO \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

HOSPITAL INSURANCE \_\_\_\_\_

MEDICAL INSURANCE \_\_\_\_\_

Requested effective date (1st or 15th), or end date of prior Medicare supplement, if replacing

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name (as it appears on your Medicare card)

Social Security Number

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Home Address, Apt. No., Suite No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Billing Address (if different from home address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Care of/Attention	Home Telephone Number ( ) _____	E-mail Address	Date of Birth
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If you have another Anthem Blue Cross Group/Individual or Blue Cross/Blue Shield out-of-state plan, indicate →	Group Number	State	Identification Number
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## Section 2 – Billing Information

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer (EFT) from your account or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

*If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling toll-free 1-800-333-3883.*

*Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando a 1-800-333-3883.*

**Please enclose check for one month premium. If you are applying for a 2-party contract, or wish to be added to an existing contract, please enclose one check for the applicable 2-party rate.**

### Section 3 – Health History

**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 Section 3 and Section 4 below. **Note:** If the answer to any of the following questions is “yes,” you might not be eligible for coverage.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 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?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past two years, have you been advised to have surgery which has not yet been done?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past five years, have you been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer’s disease, Parkinson’s disease, senile dementia, organic brain disorder or other senility disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD) or emphysema (excluding allergies and asthma)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internal cancer, leukemia, Hodgkin’s disease, insulin dependent diabetes, chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea), amputation or joint replacement due to disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?   | <input type="checkbox"/> | <input type="checkbox"/> |

### Section 3 – Health History (continued)

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

Question Number:	Specific illness, injury, procedure, surgery, hospitalization or condition	Name of Medication and Dates of Use		Name, Address, Telephone and Fax (w/area code) for Doctor	Dates of illness, injury, procedure, surgery, hospitalization or condition	
					Begin	End/Current
Example: 4a	Congestive Heart Failure	Lanoxin		Dr. John Doe (555) 555-1000/ (800) 555-2000	11/1999	7/2005
		1/2001	7/2005			

### Section 4 – Medical Information

Name of Primary Care Physician \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

### Section 5 – General Information

**I.** 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:

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? \_\_\_\_/\_\_\_\_/\_\_\_\_

D. Are you covered for medical assistance through California’s Medi-Cal program?  Yes  No

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

If yes,

i. Will Medi-Cal pay your premiums for this Medicare supplement policy?  Yes  No

ii. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?  Yes  No

Section 5 – General Information (continued)

E. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

- i. 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
- ii. Was this your first time in this type of Medicare plan?  Yes  No
- iii. Did you drop a Medicare supplement policy to enroll in this Medicare plan?  Yes  No

F. Do you have another Medicare supplement policy in force?  Yes  No

- i. If so, with what company, and what plan do you have? \_\_\_\_\_
- ii. If so, do you intend to replace your current Medicare supplement policy with this policy?  Yes  No

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

- i. If so, with what company and what kind of policy? \_\_\_\_\_

ii. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave “END” blank. START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

Please be aware that if you are currently enrolled in a Medicare Advantage plan, it is your responsibility to terminate your coverage prior to enrollment becoming effective with Anthem Blue Cross. Any unpaid claims resulting from failure to disenroll from your Medicare Advantage plan will be your responsibility.

II. 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.

**Please read the following carefully.**

- A. I agree to pay the first month's premium required for the program requested on this application, and that this payment will be returned to me if my application is rejected or will be applied to my premium if my application is accepted.
- B. If I do not qualify for guaranteed acceptance into an Anthem Blue Cross Medicare Supplement Plan, Anthem Blue Cross has the right to reject my application. If Anthem Blue Cross rejects my application, I will be notified in writing and any premium submitted with this application will be refunded. I understand and agree that if Anthem Blue Cross rejects my application, under no circumstances will any Anthem Blue Cross benefits be payable. ***Cashing of my check by Anthem Blue Cross does not constitute approval of my application.***
- C. If my application is accepted, this application will become part of the agreement between Anthem Blue Cross and myself. If this application is accepted, I further agree to be bound by the binding arbitration clause set forth in this application and I waive my right to court trial by judge or jury in the event of any dispute arising under this policy.
- D. Anthem Blue Cross may request additional information, which may delay processing of this application. If the health care provider bills for this information, Anthem Blue Cross will pay up to \$25 and I understand that I will be responsible for any difference.
- E. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross underwriting policy or terms of any Anthem Blue Cross coverage.
- F. I alone am responsible for reading and accurately completing this application. I understand that coverage under the contract will be voided only in the event that I fail to accurately respond to questions regarding my past or present health condition. 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 and that Anthem Blue Cross 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.
- G. **California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.**

**Important Information for Applicant (Please read)**

- 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 the policy, you become eligible for Medi-Cal or Medicaid, 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

## Section 6 – Conditions of Application (continued)

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 reinstated if requested within 90 days after 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 reinstated 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 Medi-Cal or Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.

## Section 7 – Authorization & Agreements

### CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR 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, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex), but not including psycho therapy 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.

**Entities or Persons Authorized to Receive:** Anthem Blue Cross or affiliate ("Anthem") our agents, employees, designees, or representatives, including your Anthem Blue Cross 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 Protected Health Information (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. *Exception:* If you qualify for Guaranteed Acceptance into this plan, you are not required to sign this authorization and we will not decline to enroll you in this plan.

**Effect of Declining:** If you decide not to sign this authorization, we may decline to enroll you in our health plan. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule. *Exception:* If you qualify for Guaranteed Acceptance into this plan, you are not required to sign this authorization and we will not decline to enroll you in this plan.

**Expiration:** This authorization will expire upon termination of any Anthem Blue Cross coverage that may be in effect.

**Right to Revoke:** You understand that you may revoke this authorization at any time by giving written notice of your revocation to:

**Anthem Blue Cross**  
**PO. Box 9063, Oxnard, CA 93031-9063**  
**Telephone 1-800-333-3883, Fax 1-805-375-0361**

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

**Section 7 – Authorization & Agreements (continued)**

You have had full opportunity to read and consider the contents of this authorization, and understand that, by signing this authorization, you are confirming your authorization of the use and/or disclosure of your Protected Health Information, as described in this authorization.

<input type="text"/>	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>Print Applicant's Name</b>		<b>Applicant's Signature</b>	<b>Date</b>

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

<input type="text"/>	<input type="text"/>
<b>Name of other person authorized to use or disclose my PHI</b>	<b>Relationship to Applicant</b>

<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
	<b>Applicant's Signature</b>	<b>Date</b>

A photocopy of this authorization is as valid as the original, and you and your Anthem agent or broker are entitled to receive a copy of this form. **YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**

- I have personally read and completed this application. I understand and agree to the Replacement Notification on page 10 of this application and to the Conditions of Application and the Authorization & Agreements in this application. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare", an informational Medicare Supplement brochure, and the "Outline of Coverage" and Premium Information for this plan.
- I acknowledge receipt of the Medicare Supplement Guaranteed Issue Guideline and I have had full opportunity to read and consider my Medicare Supplement Guaranteed Issue Rights.
- I understand that receipt of money with this application does not create Anthem Blue Cross coverage. Coverage will come into effect only if Anthem Blue Cross approves this application.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety.

<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
	<b>Applicant's Signature</b>	<b>Date of Signature</b>

**PRIORITY PROCESSING**

**Complete the Other Side of this form to enroll in the Optional Monthly Checking Account Deduction Authorization for Seniors.**

**Include one month's premium with application.**

**Attach a blank check marked "VOID".**

**A deposit slip is not acceptable.**

Section 8 – 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 OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that 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 OR ANY OTHER ISSUES RELATED TO THE PLAN.

Signature (Required)

X [ ] [ ]
Applicant Date of Signature

Optional Monthly Checking Account Deduction Authorization for Seniors.

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Subscriber Name
[ ]
[ ]
X Date

Social Security Number
Bank Name
[ ]
X Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer line toll-free at 1-800-927-HELP, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free at 1-800-434-0222, or by accessing the Department of Insurance's web site [www.insurance.ca.gov](http://www.insurance.ca.gov).

**For Agent Only (Attach additional sheets if necessary.)**

Please list all disability policies you have issued to the applicant that are still in force and all disability policies issued in the past 5 years that are no longer in force and submit with the application, as required by Insurance Code Section 10197(c):

Name of Policy	Name of Insurance Company
Policy Date From: Mo/Yr.	Address of Insurance Company
Policy Date To: Mo/Yr.	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.

**Attestation – Please check one of the following:**

- I did not assist this applicant in completing and/or submitting this application by phone, email 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), as authorized under California Health and Safety Code 1369.8(c).

	SIGNED AT
Agent's Signature Oleg Skurskiy	Date of Signature BCLNGNPVMZ (City and State)
Print Agent's Name 18375 Ventura Blvd. # 226	Agent No. 818-654-4548
Street Address Tarzana	Telephone No. CA 91356
City	State ZIP

Amount Paid with Application \$ \_\_\_\_\_ Send Agreement to:  Agent  Subscriber

Name of person who completed this application: \_\_\_\_\_

## Replacement Notification

WE ADVISE YOU TO SAVE THIS NOTICE AS IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you have furnished, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or Medicare Advantage plan and replace it with a contract to be issued by Anthem Blue Cross. Your plan contract to be issued by Anthem Blue Cross will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

### Statement to applicant by plan, solicitor, solicitor firm, or other representative:

- A.** You have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of your knowledge. The replacement contract 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.) \_\_\_\_\_
- B.** You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.
- C.** State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
- D.** If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and refund your prepaid or periodic payment as though your contract 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.
- E.** Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.

## Addendum to Medicare Supplement Applications

Mail to: Anthem Blue Cross  
P.O. Box 9063  
Oxnard, CA 93031-9063

A new law became effective January 1, 2009 (AB 2569), which requires all agents/brokers to include an attestation with each application submitted if that agent/broker assisted that applicant in completing the application.

[ \_\_\_\_\_ ]  
[Applicant's Social Security or ID No.]

**Please check one of the following and complete the information below:**

I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not assist the applicant in providing answers or responses to any questions in the application.

I assisted the applicant in 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), as authorized under California Health and Safety Code 1389.8(c).

\_\_\_\_\_  
[Electronic] Signature of Agent (*required*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
OLEG SKURSKIY

\_\_\_\_\_  
BCLNGNPVMZ

Type or Print Name

Agent Number

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