Freedom Blue (Regional PPO)
Individual Enrollment Request Form — 2011

Anthem Blue Cross

Be sure to complete the entire enrollment form. Then, **mail** the completed form to Enrollment Processing Center P.O. Box 659404 San Antonio, TX 78265-9404 ***or*** **fax** the completed form to **1-877-391-3877.**
Note: Your agent/broker may provide different instructions.

Please contact Anthem Blue Cross if you need information in another language or format (Braille).

To enroll in Freedom Blue (Regional PPO), please provide the following information.

Please check which plan you want to enroll in:

☐ **Freedom Blue Plan I (Regional PPO) $0 per month**

- ☐ Preventive Dental Package #1
  $9
- ☐ Comprehensive Dental and Vision Package #2
  $25
- ☐ Combination Package #3
  $39

Last name	**First name**	**Middle initial**	☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**
Birth date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	**Sex** ☐ M ☐ F	**Home phone number** ( )	**Alternate phone number** ( )

Permanent residence street address (P.O. box is not allowed.)

City	State	ZIP code

Mailing address (only if different from your permanent residence address)

Street address	City	State	ZIP code

E-mail address

Applicant Complete: Name _____ and Medicare ID number_____

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Please provide your Medicare insurance information.

Please take out your red, white and blue Medicare card to complete this section.

- Please fill in these blanks so they match your Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying your plan premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or electronic funds transfer (EFT) each month. You also can choose to pay your premium by automatic deduction from your Social Security benefit check each month. You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or electronic funds transfer (EFT) each month. You also can choose to pay your premium by automatic deduction from your Social Security benefit check each month. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You also can apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name _____

Bank routing number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Bank account number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Account type ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

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Please read and answer these important questions:

1. **Do you have end-stage renal disease (ESRD)?** ☐ Yes ☐ No

If you answered "yes" to this question and you don't need regular dialysis any more or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing that you don't need dialysis or that you have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to your Freedom Blue (Regional PPO)?
☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage	ID number for this coverage	Group number for this coverage
_____	_____	_____

3. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution _____

Address (number and street) and phone number of institution _____
_____

4. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

If "yes," please provide your Medicaid number _____

5. **Do you or your spouse work?** ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

_____ Spanish

_____ Large print

Please contact Anthem Blue Cross at **1-888-211-9813** if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-241-6894**.

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STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining Freedom Blue (Regional PPO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Freedom Blue (Regional PPO). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get Extra Help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on (insert date) _____.
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- ☐ None of these statements applies to me.*

*Please contact Anthem Blue Cross at **1-888-211-9813** (TTY users should call **1-800-241-6894**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week.

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Please read and sign below.

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

Freedom Blue (Regional PPO) 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 be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan automatically will end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you 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 (for example, November 15 – December 31 of every year), or under certain special circumstances.

Freedom Blue (Regional PPO) serves a specific service area. If I move out of the area that Freedom Blue (Regional PPO) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Freedom Blue (Regional PPO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Anthem Blue Cross when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare usually aren't 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 (Regional PPO) coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Anthem Blue Cross provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Anthem Blue Cross and other services contained in my Freedom Blue (Regional PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ANTHEM BLUE CROSS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Anthem Blue Cross, he/she may be paid based on my enrollment in Freedom Blue (Regional PPO).

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

Release of Information: By joining this Medicare health plan, I acknowledge that Anthem Blue Cross will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Blue Cross will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Anthem Blue Cross or by Medicare.

Applicant Complete: Name _____ and Medicare ID number_____

Signature	Today's date

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number (____) _____-_____

Relationship to Enrollee _____

Applicant: Please do not complete the following sections. *For office and agent/broker use only*.

***Internal agents or external agents/brokers, please complete*:** Coverage effective date ____/____/_____

☐ ICEP/IEP ☐ NIPR# ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

1. Was this an individual face-to-face appointment? ☐ Yes ☐ No (Do not proceed.)
2. If this was an individual face-to-face appointment, how was a scope of appointment (SOA) collected?
   ☐ Paper
   ☐ Recorded call (voice vault confirmation number _____)
3. Was the SOA signed on the same day as the appointment? ☐ Yes ☐ No (Do not proceed.)
4. If yes, please indicate the best reason below:

☐ Appointment was requested at the end of the month for following month enrollment

☐ Customer walk-in

☐ Request for individual appointment immediately following a seminar sales event

☐ Next day appointment

☐ Other _____

***Direct sales reps only*:** Complete if you assisted in enrollment.

Print name _____

Tax identification number (10 digits) or agent code (variable) |___|___|___|___|___|___|___|___|___|___|

Signature _____ Application received date _____/_____/_____

***External agents/brokers only*:** application received ___/___/___

I helped the applicant fill out this application ☐ Yes ☐ No

Please check the identification number to use for commission payment:

Agent/broker's tax identification number

|5|6|4|6|3|6|2|2|0|__|

Agency tax identification number

|9|5|-|4|2|3|9|5|7|1|

External agent/broker's

Signature _____

***Please complete all lines below*.**

Agent/broker's printed name Vic Vartanian

Agency name First Eagle Insurance

333 S. Central Ave., Ste. 101
Street address

Glendale, Ca. 91204
City State ZIP code

Phone number (877) 447-4999

Fax number (818) 500-1855

E-mail address vic@hipi999.com

Applicant Complete: Name _____ and Medicare ID number_____

A health plan with a Medicare contract.

Anthem Blue Cross Life and Health Insurance Company (Anthem) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Advantage Regional PPO plan(s) (MAPD-RPPO) noted. Anthem is the risk-bearing entity licensed under applicable state law to offer the MAPD-RPPO plan(s) noted. Anthem has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the MAPD-RPPO plan(s) available in this region. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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