Anthem Blue Cross

Fax Application to: 800-995-9913

# SENIOR ENROLLMENT APPLICATION

**For Seniors with Medicare Parts A and B**

Please complete entire application.

Application for a Medicare SELECT Plan or Standard Plan A to supplement Medicare (Select one)

- ❑ Blue Cross Senior Classic℠ 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.

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, or end date of prior Medicare supplement, if replacing

_____/_____/_____

Name (as it appears on your Medicare card)

Social Security Number

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 |
|---|---|---|---|

| If transferring from another Anthem Blue Cross Group/Individual or Blue Cross/ Blue Shield out-of-state plan, indicate ⇨ | Group Number | State | Identification Number |
|---|---|---|---|

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 When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.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 1-888-211-9813.*

*Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando a 1-888-211-9813.*

**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.**

## 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.

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

If you think you qualify for guaranteed acceptance into an Anthem Blue Cross Medicare Supplement Plan please write the number of the qualifying situation, as described in the Medicare Supplement Guaranteed Issue Guideline, in the Box below. Please attach proper documentation to validate your eligibility for Guaranteed Acceptance.

I believe I qualify for guaranteed acceptance based on situation number: ☐

If you do not qualify for enrollment on the basis of guaranteed issue, you must complete Section 2 and Section 3 below. If the answer to any of the following questions is "yes," you are not eligible for coverage.

| | Yes | No |
|---|---|---|
| **A.** 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? | ☐ | ☐ |
| **B.** Within the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? | ☐ | ☐ |
| **C.** Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements.) | ☐ | ☐ |
| **D.** Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin's disease, coronary artery disease, heart attack, nephritis, kidney failure, stroke or brain disorder? | ☐ | ☐ |
| **E.** Within the past 5 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, organ transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight? | ☐ | ☐ |

## Section 3 – Medical Information

Name of Primary Care Physician _____ Telephone (_____) _____

Address_____

List all prescription drugs currently prescribed for your use: (If none, write "none") _____

_____

List name, address and telephone number of prescribing physician if different from above:

_____

_____

If applying for, but not accepted for **Blue Cross Senior Classic I** or **Blue Cross Senior Classic J**, if I qualify, I would like to be enrolled in: **Blue Cross Senior Classic F** ☐ **or**

**Blue Cross Senior Classic C** ☐

## Section 4 – 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:

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?

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

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

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? _____

## Section 4 – General Information (continued)

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.

## Section 5 – Conditions of Application.

### Please read the following carefully.

**A.** I agree to pay an application fee equal to the subscription charges required for the program requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the subscription charges 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 application fees 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.

## Section 5 – Conditions of Application. (continued)

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 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 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 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 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 6 – Binding Arbitration

**Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. The Member and Anthem Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.**

**California Health & Safety Code section 1363.1 requires that any arbitration agreement include 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."**

**The Member and Anthem Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross and Anthem Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member. The arbitration findings will be final and binding except to the extent that state or federal law provides for the**

## Section 6 – Binding Arbitration (continued)

**judicial review of arbitration proceedings. The arbitration is initiated by the Member making written demand on Anthem Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross cannot agree.**

**The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the costs of the arbitration. Please send all Binding Arbitration demands in writing to:**

**Anthem Blue Cross**
**P.O. Box 9063, Oxnard, CA 93031-9063**

| X | |
|---|---|
| **Applicant's Signature** | **Date of Signature** |

## 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 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.

**Entities or Persons Authorized to Receive:** Anthem Blue Cross or affiliate ("Anthem") its agents, employees, designees, or representatives, including my 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.

***(This section is continued on next page)***

## Section 7 – Authorization & Agreements (continued)

**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**
**Telephone 1-800-333-3883, Fax 1-805-375-0361**

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 Protected Health Information, as described in this authorization.

| X | X | |
|---|---|---|
| **Print Name** | **Signature** | **Date** |

A photocopy of this authorization is as valid as the original, and I and my 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 11 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", the Provider Directory, and the Blue Cross Senior Classic F Plan with the AdvantageCare Rider brochure, which includes the Medicare Select Disclosures, Grievance Procedures, "Outline of Coverage" and Premium Information.
- 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 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.

| X | X | |
|---|---|---|
| **Print Name** | **Signature** | **Date** |

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.

## For Agent Only

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):

| Date | Name of Policy | Name and Address of Insurance Company |
|---|---|---|
| From: Mo./Yr. | | Name |
| | | Address |
| To: Mo./Yr. | | City/State |

(Attach additional sheets if necessary)

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's Signature John Conner Date of Signature SIGNED AT Sacramento, CA (City and State)

Print Agent's Name Agent No. CNKFGRRNQZ

Street Address 10425 Saddle Creek Dr Telephone No. 800-700-1246

City Sacramento State CA ZIP 95829

Amount Paid With Application $_____

Send Agreement and I.D. Card To: ❑ Agent ☒ Subscriber

Name of person who completed this application: _____

## 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 | Social Security Number |
|---|---|
| Group Number | Bank Name |
| X Date | X Date |

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

## Section 8 – Authorization & Agreements

The following authorization is voluntary.
Only complete the section below if you wish to disclose your Private Health Information (PHI) to a third party (spouse, family member, or any other individual). Signing this form will allow a third party the ability to call for information regarding your application or claims.

### SECTION A: Individual authorizing use and/or disclosure

Name _____ Telephone _____

Address _____ Member Identification Number _____

### SECTION B: The use and/or disclosure being authorized

PHI to be Used and/or Disclosed: **(Specifically describe the PHI to be used and/or disclosed)**

_____

_____

❏ Check if this authorization is for psychotherapy notes.

**If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information (PHI).**

Entities or Persons Authorized to Use or Disclose: **(Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above).**

Anthem _____ _____

_____ _____

Entities of Persons Authorized to Receive: **(Name or specifically identify the persons and/or organizations {or the classes of persons and/or organizations}, including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above).**

Anthem _____ _____

_____ _____

**Purpose of this Authorization:**

❏ At request of individual

❏ For the following purposes:

_____

_____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

## SECTION C: Expiration and revocation

Expiration: This authorization will expire (complete one)

❏ On _____ / _____ / _____

❏ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized).

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. 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.

Anthem Blue Cross
Contact Office

1-800-333-3883 — Telephone
1-805-375-0361 — Fax

P.O. Box 9063 Oxnard, CA 93031-9063
Address

## INDIVIDUAL'S SIGNATURE

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

_____
Print Name

_____
Signature — Date

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

_____
Personal Representative's Name

_____
Signature — Date

_____
Relationship to Individual

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

THIS APPLICATION WILL BE RETURNED TO YOU AFTER PROCESSING.

## 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 Standard Plan A or Medicare Select 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 Select or Standard Plan A 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.

**Fax completed Application to 800-995-9913**

**Questions call: John Conner at 800-700-1246**

MAILING ADDRESS – **Applicant: Please return application to agent or mail to:**

**Enrollment Processing Center**
P.O. Box 5007
Middletown, NY 10940-9007

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association.
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®The Blue Cross names and symbols are registered marks of the Blue Cross Association.