

**Anthem Blue Cross and Blue Shield
Medicare Supplement Application — Maine**

New Enrollment Change to Enrollment


Fax Application to: 800-995-9913

Send no money now! For assistance, please contact us at 800-413-3103 or contact your Anthem Blue Cross and Blue Shield Insurance Agent. To be considered for coverage, you must live in Maine.

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

| | | | | | |
|--|--|--|--------|-------|--|
| Last Name | | First Name | | MI | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Home Street Address | | City | County | State | Zip Code |
| Social Security Number ____-____-____ | | Date of Birth ____/____/____ | | Age | Home Phone Number () |
| E-mail Address (optional) | | Preferred Language Spoken: _____ Written: _____ | | | |

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

| | |
|---|--|
| Medicare Claim Number: _____ |  MEDICARE HEALTH INSURANCE 1-800-MEDICARE (1-800-633-4227) |
| Hospital (Part A) Effective Date: _____ MONTH/YEAR | NAME OF BENEFICIARY JANE DOE |
| Medical (Part B) Effective Date: _____ MONTH/YEAR | MEDICARE CLAIM NUMBER 000-00-0000-A |
| | SEX FEMALE |
| | IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B) |
| | EFFECTIVE DATE 07-01-2010 07-01-2010 |

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

Name _____ Medicare Claim Number _____

Anthem Blue Cross and Blue Shield Medicare Supplement Identification Number _____

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

Section C: Plan Chosen (Check only one plan below).

If you are age 65 or over, turning 65 in the next 3 months or under age 65 and eligible for Medicare due to a disability, the following plan(s) are available to you:

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

Section D: Effective Date

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

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

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

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

 / 01 /
M M DD Y Y Y Y

Section E: Billing Preference

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

- Monthly* Quarterly Annually

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

How do you want to pay your premiums?

- Automatic Bank Draft on the 5th day of the month, from Checking or Savings account

NOTE: *For Automatic Bank Draft, please complete the enclosed Premium Payment Form.*

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

Name _____ Street Address/PO Box _____ City _____ State _____ ZIP Code _____

Section F: Select a “Third Party Designee” (Optional)

Under Maine State law, customers with Medicare Supplement insurance may designate another person (a third party) to receive a notice of nonpayment of insurance premiums. In the event the premium is not received by the due date, a THIRD PARTY BILLING STATEMENT will be sent to the designated person. If you wish to authorize a person to receive this notice of payment due, provide the information requested below. The person you select MUST sign.

| | | |
|-----------|------------|----|
| Last Name | First Name | MI |
|-----------|------------|----|

| | |
|---------------------|------------------|
| Home Street Address | Apartment Number |
|---------------------|------------------|

| | | |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

Designated Third Party Signature: _____ Date: _____

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

Anthem Blue Cross and Blue Shield may request additional information, which may delay processing of this application.

Please read the six statements below.

Important Statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid, for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to 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 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.
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 of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the 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 Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

General Information

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

(Please answer all questions.)

To the best of your knowledge:

1. a. Did you turn age 65 in the last 6 months? Yes No
b. Did you enroll in Medicare Part B in the last 6 months? Yes No
c. If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program? Yes No
[Note to Applicant: If you are participating in a "Spend-Down Program" and have not met your Share of Cost, please answer "No" to this question.]

(continued)

Section G: Conditions of Application (continued)

If yes,

- a. Will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
- b. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? Yes No
3. a. If you had coverage from any Medicare plan other than original Medicare within the past 90 days (for example, a Medicare Advantage plan, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START ____/____/____ END ____/____/____
- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
- c. Was this your first time in this type of Medicare plan? Yes No
- d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No
4. a. Do you have another Medicare Supplement policy in force? Yes No
- b. If so, with what company, and what plan do you have?

- c. If so, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
5. Have you had coverage under any other health insurance within the past 90 days? Yes No
(for example, an employer, union or individual plan)
- a. If so, with what company and what kind of policy? _____
- b. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
START ____/____/____ END ____/____/____

Section H: Authorizations and Agreements

I, the applicant or my authorized representative, have read and understand this Application in its entirety.

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

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

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

I, the applicant or my authorized representative, authorize Anthem Blue Cross and Blue Shield (the Company) to send, to the Third Party Designee, a THIRD PARTY BILLING STATEMENT. This authorization is valid for the duration of my coverage unless a different expiration date is indicated here: _____ (specify month, day, year) or I revoke the designation in writing, except to the extent that action has been taken in reliance upon it. I understand that the person/entity I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect the information.

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

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

Policy Number: _____

(continued)

p4 of 8

Section H: Authorizations and Agreements (continued)

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

| | |
|------------------------|------------------------|
| Name: | Relationship: |
| DOB: ___ / ___ / _____ | SSN: ___ ___ _____ |
| Name: | Relationship: |
| DOB: ___ / ___ / _____ | SSN: ___ ___ _____ |
| Name: | Relationship: |
| DOB: ___ / ___ / _____ | SSN: ___ ___ _____ |

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

I, the applicant or my authorized representative, understand that there is a 6-month benefit waiting period for coverage of any condition for which I received medical treatment or advice within the 6 months prior to the effective date of this Medicare Supplement policy. I understand that the time I was covered under any other health insurance will be counted toward this 6-month benefit waiting period, if there is not a break in coverage greater than 90 days between the termination of the other coverage and the effective date of this Medicare Supplement policy.

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

I, the applicant or my authorized representative, alone have responsibility for accurately completing this application. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted. I understand that the company may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions.

Conditioned Authorization to Use or Obtain Medical Information to Pay Claims

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

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

Section H: Authorizations and Agreements (continued)

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

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

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

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

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

Anthem Blue Cross and Blue Shield, 2 Gannett Drive, South Portland, ME 04106-6911

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

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

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

| | | |
|---|----------------------------------|-------------|
| | X | |
| <i>Print Applicant's Name</i> | <i>Applicant's Signature</i> | <i>Date</i> |
| Name of the other person or persons authorized to receive my PHI: | | |
| | | |
| <i>Name of Authorized Person</i> | <i>Relationship to Applicant</i> | |
| X | | |
| | <i>Applicant's Signature</i> | <i>Date</i> |
| A photocopy of this authorization is as valid as the original, and I and my Anthem Blue Cross and Blue Shield agent or broker are entitled to receive a copy of this form after I sign it. | | |

Section I: Policy or Certificate Issuance

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

To ensure timely processing, verify the following:

- 1) Complete, sign and date all sections as indicated by signature boxes.
- 2) If you want the convenience of automatic bank draft for payment purposes, be sure to complete the **Premium Payment Form**.

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

Are you working with an insurance agent?
(No additional charges when working with your agent)

Did you contact Anthem Blue Cross and Blue Shield directly?

If yes, mail to:

Anthem Blue Cross Blue Shield
PO Box 14024
Roanoke, VA 24038-4024 OR
Fax to: 888-449-4807

If yes, mail to:

Enrollment Processing Center
PO Box 5007
Middletown, NY 10940-9007 OR
Fax to: 888-884-5736

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

All statements and descriptions in any application for insurance, by or on behalf of the insured, are deemed to be representations and not warranties.

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

Date

X

X

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

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

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

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

Agency No.: _____ Agent/Broker No.: _____
(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name: John Conner Phone No. (_____) 800-700-1246

Fax No. (_____) 800-700-1246 E-mail address: john@johnconner.com

Street Address 10425 Saddle Creek Drive

Sacramento

CA

95829

City

State

ZIP Code

Attestation - Please check one of the following:

- I did not assist this applicant in completing and/or submitting this application by phone, e-mail or in person.
- I assisted the applicant in completing and/or submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Notice: If you state as an agent any material fact that you know to be false, you are subject to a civil penalty.

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

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

Name of Policy

Name of Insurance Company

Policy Date from: ____ / ____
 M M Y Y Y Y

Street Address of Insurance Company

Policy Date from: ____ / ____
 M M Y Y Y Y

City/State of Insurance Company

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

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

Agent/Broker: Submit completed application to:

Anthem Blue Cross Blue Shield
PO Box 14024
Roanoke, VA 24038-4024
or Fax to 888-449-4807

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

Anthem Blue Cross and Blue Shield
2 Gannett Drive, South Portland, ME 04106-6911

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

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

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

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

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

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

Other. (please specify) _____

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

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

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

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

Premium Payment Form

(Please Print Clearly)



Health. Join In.

Save \$2 on Your Monthly Premium — Enroll in Automatic Bank Draft

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

Applicant's Full Name: _____ Date of Application _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: () _____

Please Return this Form With Your Application.

Section 1. Amount of Premium

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

Section 2: Paying by Monthly Automatic Bank Account Withdrawal

Yes, I would like to pay my premium by monthly automatic bank account withdrawal.

Please deduct my premium from my/our bank account for *(check one)*:

- My first month payment only
- My first and ongoing payments
- My ongoing payments only (I am making my first payment by another method)

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

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

- Checking Account:** Personal Business
- Savings Account:** Personal Business

named below and I/we authorize the financial
(continued, next column)

institution to charge such withdrawals to my/our account.

Provide the following bank account information*

Name(s) on Checking/Savings Account:

Name of Bank (or other Financial Institution):

Financial Institution Routing No.:

(first 9 digits in lower left corner of check/deposit slip)

Account No.: _____

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

Authorization:

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

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

X _____

X _____