# Anthem Blue Cross MedicareRx (PDP)

## Medicare Prescription Drug Plan

## Individual Enrollment Form — 2018

***Be sure to complete the entire enrollment form***. Then, **mail** the completed form to **P.O. Box 659404 San Antonio TX, 78265-9863** ***or*** **fax** the completed form to **1-877-391-3877**. You can also enroll online at **https://shop.anthem.com/medicare/ca.** ***Note:*** Your agent/broker may provide different instructions.

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

| **Please check which plan you want to enroll in.** | | |
|---|---|---|
| ☐ **Anthem Blue Cross MedicareRx Standard (PDP) $83.20 per month** | ☐ **Anthem Blue Cross MedicareRx Plus (PDP) $119.90 per month** | ☐ **Anthem Blue Cross MedicareRx Gold (PDP) $169.80 per month** |

| **Last name** | **First name** | **MI** | ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** |
|---|---|---|---|
| | | | |

| **Birthdate** (MM/DD/YYYY) | **Sex** ☐ M ☐ F | **Home phone number** | **Alternate phone number** |
|---|---|---|---|
| | | | |

| **Permanent residence street address** (P.O. Box is not allowed.) | | | |
|---|---|---|---|
| | | | |
| City | State | ZIP code | County |
| | | | |

| **Mailing address** (only if different from your permanent residence address) | | |
|---|---|---|
| | | |
| City | State | ZIP code |
| | | |

| **Please provide your Medicare insurance information** | |
|---|---|
| Please take out your red, white and blue Medicare card to complete this section.<br><br>• Fill out this information as it appears on your Medicare card.<br><br>-OR-<br><br>• Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. | Name (as it appears on your Medicare card): _____<br><br>Medicare Number: _____<br><br>Is Entitled To: Effective Date:<br><br>HOSPITAL (Part A) _____<br><br>MEDICAL (Part B) _____<br><br>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan. |

**Applicant Complete**: Name _____ and Medicare Claim Number _____



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## Paying your plan premium

**You can pay your monthly plan premium (including any late enrollment penalty you 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 or Railroad Retirement Board (RRB) benefit check each month.**

**If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Anthem Blue Cross.**

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 won't have a 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 choose one of the options below:**

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

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your ***first*** payment.) Please complete steps 1, 2 and 3 below:

1) Account Type ☐ **Checking:** Must enclose a **VOIDED check**. ☐ **Savings:** Must enclose letter from financial institution with account information.

2) Please complete the following information for your account

Account holder name _____ Account number _____

Bank routing number _____ Bank name _____

(This is the first 9 digits printed on the lower left corner of your check.)

3) ☐ I authorize the bank above to allow this monthly deduction of the amount from the account above.

☐ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Applicant Complete**: Name _____ and Medicare Claim Number _____



Confirmation No:

**Please read and answer these important questions:**

1. **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 your current prescription drug coverage be ending?** ☐ Yes ☐ No ☐ N/A

**Will you continue to have other prescription drug coverage?** ☐ Yes ☐ No ☐ N/A

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

**Dates Covered**: **Start** ___ ___ _____ **End** ___ ___ _____ Name of other coverage _____

ID # for this coverage _____ Group # for this coverage _____

2. **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 _____

City _____ State _____ ZIP code _____ Phone number _____

**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

Assistance for the visually impaired:

☐ Voice-Enabled (Audio) PDF ☐ Large Print

Please contact Anthem Blue Cross MedicareRx (PDP) at **1-800-928-6201** if you need information in another format or language than what is listed above. TTY users should call **711**. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

# STOP

## Please read this important information.

**If you are a member of a Medicare Advantage plan (like an HMO or PPO)**, you may already have Part D prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Anthem Blue Cross your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

**If you currently have health coverage from an employer or union, joining Anthem Blue Cross could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Anthem Blue Cross.** 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 Prescription Drug Plan (PDP) only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year.** Additionally, there are exceptions—i.e., Initial Enrollment Period (IEP) and Special Enrollment Periods (SEPs)—that may allow you to enroll in a Prescription Drug Plan outside of this period.

Please read the following statements carefully and check all of the boxes where there is a statement that applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

**Applicant Complete**: Name _____ and Medicare Claim Number _____



White - agent copy; Yellow - member copy

Confirmation No:

**NOTE: You must select at least one of the options below.**

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (IEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ 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) _____ . (SEP)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)
- ☐ I get Extra Help paying for Medicare prescription drug coverage. (SEP)
- ☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on (insert date) _____ . (SEP)
- ☐ 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) _____ . (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____ . (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ . (SEP)
- ☐ I am leaving employer or union coverage on (insert date) _____ . (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ . (SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
- ☐ I am making this enrollment request between January 1 and February 14, and I recently ended or plan on ending my enrollment in a Medicare Advantage plan. The date that my Medicare Advantage plan ends/ ended on is (insert date) _____ .
- ☐ I was recently released from incarceration. I was released on (insert date) _____ . (SEP)
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____ . (SEP)
- ☐ Other* _____

*Please contact Anthem Blue Cross at **1-800-928-6201.** Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30, (TTY users should call **711**) to see if you are eligible to enroll.

**Please read and sign below.**

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

Anthem Blue Cross MedicareRx (PDP) is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Anthem Blue Cross of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in Anthem Blue Cross will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

**Applicant Complete**: Name _____ and Medicare Claim Number _____



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Confirmation No:

Anthem Blue Cross MedicareRx (PDP) serves a specific service area. If I move out of the area that Anthem Blue Cross serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Anthem Blue Cross network pharmacies. Once I am a member of Anthem Blue Cross MedicareRx (PDP), 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. I understand that if I have had a prior break in creditable prescription drug coverage (as good as Medicare's), or leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage. 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 Anthem Blue Cross MedicareRx (PDP). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

**Release of Information:** By joining this Medicare prescription drug 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 State law 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 from Medicare.

**Signature Required to process your application.**

| **Applicant signature**<br>X | **Today's date** |
|---|---|
| **Desired plan effective date:** | |

| **Authorized Representative Information Only** | | |
|---|---|---|
| **All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.** | | |
| **Name** | | |
| **Address** | | |
| **City** | **State** | **ZIP code** |
| **Phone Number** | **Relationship to Enrollee** | |

**Applicant Complete**: Name _____ and Medicare Claim Number _____



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Confirmation No:

**Applicant: Please do not complete the following sections.**
***Agent/Broker:*** **Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.**

Coverage effective date _____ PLAN ID #: _____

☐ IEP ☐ AEP ☐ SEP (type): _____ ☐ Not eligible

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

Was this an individual face-to-face appointment? ☐ No ☐ Yes (if yes, how was a scope of appointment (SOA) collected)? ☐ Paper ☐ Recorded call (voice recording ID) _____

Print name _____

Writing Agent TIN (10 digits)/Agent Code___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency TIN (10 digits) or Agency Code___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency Name _____

Street address _____

City _____ State _____ ZIP code _____

Phone _____ Fax _____

Email _____

Signature _____ Application received date _____

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health depends on contract renewal.

Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare & Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. Anthem is the state-licensed, risk-bearing entity offering these plans. Anthem has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs 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.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

**Applicant Complete**: Name _____ and Medicare Claim Number _____



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Confirmation No:

# Want an easier way to pay your monthly plan premiums (payments)? Enroll in an Automatic Payment Option!

**Benefits of enrolling in automatic payment options:**

- **Avoid a lapse in your policy:** Your plan benefits are never at stake because your monthly plan payments will always be on time.
- **Potentially save money**: You'll use fewer checks and stamps to mail your payment each month.
- **Less paperwork:** Just fill out a simple form to start automatic deductions and put an end to writing checks. **Note:** If you choose automatic payment options, you will no longer get a monthly paper bill by mail.
- **Quick and easy sign-up:** Complete the Member Information and one of the Authorization forms on the reverse side of this page – make a copy for your records. Next, you'll receive a letter telling you when your bank withdrawal, SSA or RRB deduction will start.
- **The service is free:** By signing up for one of these services, you can have peace of mind knowing your policy is paid on time, every time – and at no extra charge to you!

**Your automatic payment options:**

- **Bank account withdrawal:** Your monthly plan payment is withdrawn (taken) from your bank account, usually between the 3rd and 9th day of each month.
- **Social Security Administration (SSA) deduction:** Your monthly payment is taken from your SSA check.
- **Railroad Retirement Board (RRB) deduction:** Your monthly payment is taken from your RRB check.

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Y0114_18_31781_R_155 CMS approved 8/14/2017

## More to know about automatic payment options

### If you choose:

**Bank account withdrawal**

- Depending on when we receive your request, the first payment taken from your bank account may be more than one monthly payment. After that, only one regular payment will be taken from your bank account each month.

**SSA or RRB deduction**

- You should **only choose this option if** your SSA or RRB check is at least three times your monthly premium. Here's why:
  - Your first deduction could be more than one monthly payment because the federal government may begin to deduct your payment two or three months after your SSA or RRB deduction is approved. After that, only one monthly payment will be taken each month.
- To avoid policy disruptions, you must keep paying your monthly plan payments until you get an acceptance letter for your SSA or RRB deduction.

### If you receive:

**Premium help from a State Pharmacy Assistance Program (SPAP)**

Your first deduction could be more than one monthly payment because the federal government may begin to deduct your payment two or three months after your SSA or RRB deduction is approved. After that, only one monthly payment will be taken each month.

**Note:** We recommend that you do not choose the SSA or RRB deduction option because the SSA or RRB will not know that you do not pay the full monthly premium. This means, the entire monthly amount will be deducted from your monthly SSA or RRB check, instead of the balance you owe after the SPAP pays.

**Extra Help with your prescription drug costs from the federal government through Low-Income Subsidy (LIS), and Medicare covers some of your premium**

The SSA or RRB will know that part of your premium is paid by the government. They will deduct only the remaining amount from your SSA or RRB check.

**Mail your completed form to:**

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9282
Oxnard, CA 93031-9282

**Or, fax to:**
**1-805-713-5986**

**Question? We are here to help you!**

If you have any questions or concerns, please call us at the phone number listed on your member ID card. Our hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

## Member Information
*(Please complete for bank account withdrawal, SSA or RRB deduction option.)*

| First name | Last name | MI | Member identification number **(Refer to your member ID card.)** |
|---|---|---|---|
| | | | |

| Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Contact person | Phone number ( ) |
|---|---|
| | |

| Check one: ☐ Choosing an option for the first time ☐ Changing options or information | Requested effective date *(must be the first of the month)* |
|---|---|
| | |

## Bank Account Withdrawal Authorization Form
*(Only complete if you do not want SSA or RRB deductions.)*

| Financial institution name | Name on account |
|---|---|
| | |

| Financial institution street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Account number | Bank ABA routing number *(first 9 digits, lower left corner of check)* |
|---|---|
| | |

Bank account type: ☐ Checking ☐ Savings

- **For checking account deduction, please attach a blank voided check.**
- **For savings account deduction, please include a notice from your financial institution showing the account and bank routing numbers.**

**I authorize the financial institution named above** to allow Anthem Blue Cross (the Company) to deduct my Medicare Part D prescription drug plan payments from the account identified above. This authorization will remain in effect until I contact customer service and request termination of the automatic payment from the above-named financial institution. The Company and the financial institution will be given reasonable time to act on my request. ***I understand that this authorization is valid for 60 days after the Centers for Medicare & Medicaid Services confirms my membership. If automatic withdrawal is not established with my bank by that time, I will need to complete a new authorization form.***

## Social Security and Railroad Retirement Board Deduction Authorization Form
*(Do not complete this section if you are requesting bank account withdrawals.)*

☐ **I would like the payment for my Medicare Part D prescription drug plan deducted from my SSA or RRB monthly benefit check.**

## Please read and sign below.

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

| Member or Authorized Signature* | Date |
|---|---|
| | |

**If you are the authorized representative, you must provide the following information:*

| Name | Phone number ( ) | Relationship to enrollee |
|---|---|---|
| | | |

| Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

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