Anthem

Enrollment Instructions

Ready to enroll? Here are some options.

- Fill out your application online at **anthem.com** (the fastest way).
- Give us a call at **1-888-211-9813**.
- Work directly with your insurance agent.
- Fill out the paper application and fax or mail it back.

Have questions?

We're here to help.
Just give us a call:
1-888-211-9813

It's easy to get started. Here's what to do:

1. Pick the plan that's best for you.
2. Fill out all sections on the application that apply to you.
3. Select how you want to pay your monthly premium.
   **If you choose Automatic Bank Draft, don't forget to send us the Premium Payment Form.*
4. Sign and date the application and send it to us. It's a good idea to keep a copy for your own records.

Please send the entire Application (including any additional forms):

Fax to (preferred):
1-844-236-7967

OR, mail to:
Anthem Blue Cross
P.O. Box 659816
San Antonio, TX 78265-9116

PLEASE NOTE

You must live in California to be considered for coverage.

Please answer all questions fully, and submit your application within 90 days of the signature date. Your requested effective date must be within 180 days of application signature for guaranteed acceptance applicants and 90 days for applicants subject to medical underwriting.

The application has two sections. If you're applying outside of your open enrollment or a guaranteed issue period, you'll need to complete Section 2 of the application.

Anthem

Application for Medicare Supplement and Anthem Extras – California

☐ New Enrollment
☐ Change to Existing Anthem Medicare Supplement Plan

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116

Section 1a: Applicant Information

(Please print your name as it appears on your Medicare ID card and use black ink only.)

Last Name	First Name	MI	Sex ☐ M ☐ F

Home Street Address (Physical Address, not a P.O. Box)	Apt #

City	County	State	Zip Code

Mailing Address (if different than above)	City	State	Zip Code

Billing Address (if different than above)	City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Phone Number
/ /	( )

Language Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Please complete the information below using your Medicare ID card (include all letters and numbers).

Medicare Number: _____

Hospital (Part A) Effective Date: _____ / 01 / _____
MM DD YYYY

Medical (Part B) Effective Date: _____ / 01 / _____
MM DD YYYY

Section 1b: Plan Selection

If applying due to a Guaranteed Issue situation, see **Section 1e** as your plan options may be limited.

Have you used tobacco products of any form (including e-cigs) in the past 12 months? ..... ☐ **Yes** ☐ **No**

I would like to apply for Medicare Supplement Plan (check only one box):

☐ Plan A* ☐ Plan F*▲ ☐ Innovative F*▲ ☐ Plan G* ☐ Plan N*

* If you are under age 65, and within six (6) months of your enrollment into Medicare Part B or your notice of eligibility for Medicare due to disability, these Plan(s) are available to you. (Exclusion: Those eligible for Medicare due to ESRD (End-stage Renal Disease).) You may enroll in Plan G only if you first became eligible for Medicare on or after January 1, 2020.

▲ You may enroll in Plans F or Innovative F only if you first became eligible for Medicare **before January 1, 2020**.

Requested Policy Effective Date: _____ / _____ / _____
MM DD YYYY

Coverage is effective as of the 1st of the month following approval of your completed application unless continuation of coverage requires you to request a date other than the 1st of the month.

Have you purchased a stand-alone Prescription Drug Plan (PDP)? ..... ☐ **Yes** ☐ **No**

a. If yes, with what company? _____ PDP Effective Date: ____ / ____ / _____

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section 1c: How Do You Wish to Pay Your Premium? (SEND NO MONEY NOW!)

Automated Bank Draft*

- ☐ Monthly – save $2 per month
- ☐ Quarterly
- ☐ Annual – save $48 per year

Paper Bill (Send to **Billing Address** in Section A)

- ☐ Monthly
- ☐ Quarterly
- ☐ Annual – save $48 per year

* Please complete the **Premium Payment Form**.

Household Discount – other Household member – Save 5%:

When more than one member in the same household enrolls in a Medicare Supplement plan with us, both parties may qualify for our Household Discount.

Last Name _____ First Name _____ MI _____

Medicare Number: _____

Anthem Member ID Number: _____

Section 1d: Other Coverage Information

Important Statements

Please read the statements below, then answer all questions to the best of your knowledge.

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 and may not need a Medicare Supplement policy. If you are eligible for the Qualified Medicare Beneficiary (QMB) Program you cannot purchase a Medicare Supplement plan as it duplicates coverage.

4. If after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medi-Cal, for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, 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 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 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 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 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 1d: Other Coverage Information *(continued)*

RESPONSES TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR YOUR PROTECTION. To the best of your knowledge, please answer all questions by marking "Yes" or "No" with an "X". If you recently lost, are losing or replacing other health insurance coverage and received a notice stating 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 with your Application.**

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**

If yes, what is the effective date? _____

---

2. Are you covered for medical assistance through the state Medi-Cal program? ☐ **Yes** ☐ **No**
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

If yes,

a. Will Medi-Cal pay your premiums for this Medicare Supplement policy? ☐ **Yes** ☐ **No**

b. Do you receive any benefits from Medi-Cal **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 63 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. (If you know your upcoming coverage end date, then enter that date).

START _____ / _____ / _____ END _____ / _____ / _____

b. If ending, indicate reason why your coverage is ending: _____

c. 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**

d. Was this your first time in this type of Medicare plan? ☐ **Yes** ☐ **No**

e. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ **Yes** ☐ **No**

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4. a. Do you currently have a Medicare Supplement policy in force? ☐ **Yes** ☐ **No**

b. If yes, Company: _____ Plan: _____

Do you intend to replace your current Medicare Supplement policy with this policy? ☐ **Yes** ☐ **No**

c. If yes, what is your expected "END" Date? END _____ / _____ / _____

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

a. If yes, Company: _____ Policy Type: _____

b. If yes, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. If you know your coverage end date, then enter that date.)

START _____ / _____ / _____ END _____ / _____ / _____

c. If ending, indicate reason why your coverage is ending: _____

☐ Voluntary ☐ Involuntary

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section 1e: Open Enrollment/Guaranteed Issue

☐ Turning age 65 or enrolling in Medicare Part A and/or B

☐ Qualify due to a Guaranteed Issue situation. Provide **situation #**_____ from the Guaranteed Issue Guidelines included.

If you did not check one of the above boxes, you will need to complete Section 2 of the Application.

If replacing a Medicare Supplement or Medicare Advantage plan, please be sure to complete and return the **Notice of Replacement of Coverage** form and submit with your application.

Section 1f: Anthem Extras Packages (Optional Benefits – Additional Premiums Apply)

To be eligible for this coverage, you must be at least 65 years of age or older when the policy becomes effective.

If you currently have dental coverage through Anthem Blue Cross, please check the type of coverage.

☐ Individual Dental ☐ Group Dental Identification Number: _____

If you are still covered under this plan, leave "END" blank..... START ____ / ____ / ____ END ____ / ____ / ___

The **effective date** will be the same as the effective date on **page 2** of the Medicare Supplement application.

Anthem Extras Offerings:

Medicare Supplement Innovative F

☐ Senior Standard Dental
☐ Senior Premium Dental
☐ Senior Premium Plus Dental
☐ Premium Plus Dental (only)

All Other Medicare Supplement Plans

☐ Standard Package
☐ Premium Package
☐ Premium Plus Package
☐ Premium Plus Dental (**only**)

Billing/Payment options:

Select One: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Select One: ☐ Paper Statement (mailed to **Billing Address** in Section A)

☐ Automatic Bank Draft (Premium deducted same day as your effective date – **Premium Payment Form required)**

Section 1g: Authorizations and Agreements

I, the applicant or my authorized representative:

1. affirm all answers provided on this application are true, complete and correct **(including information relating to Medicare coverage) and that any false statement or misrepresentation on the Application may result in loss of coverage under the policy** and that it is my/our responsibility for accurately completing this Application;
2. understand it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits;
3. understand if coverage is rescinded for fraud or intentionally misleading statements Anthem Blue Cross will reimburse any premium paid less any claims paid and I/we will be responsible for claims paid exceeding any premium paid;
4. understand that I/we are responsible for notifying Anthem Blue Cross in writing of any new/changes to information on this application before coverage becomes effective that makes my application incorrect or incomplete;
5. understand if I am applying for coverage and am not in a guaranteed issue period that there is a six-month benefit waiting period for any condition that I received medical treatment or advice in the six months prior to the effective date of this Medicare Supplement policy. Prior health insurance coverage will be counted toward this 6-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section 1g: Authorizations and Agreements *(continued)*

6. understand the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy, premium or terms of any Company coverage and that he/she may be compensated based on my enrollment;

7. understand upon acceptance that my Application will become part of the agreement between the Company and myself;

8. authorize Anthem Blue Cross to use and disclose my personal information when necessary for the operation of my health or other related activities and that Anthem Blue Cross will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

9. understand that my payment by check (or resubmission due to insufficient funds) may be converted to an electronic Automated Clearinghouse (ACH) debit transaction, that my check will not be returned to me and that this process will not enroll me in any automatic debit process;

10. understand 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 Managed Health Care's consumer toll-free telephone number **1-888-466-2219**, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's internet website **(www.dmhc.ca.gov).**

11. acknowledge responsibility for any overdraft fees permitted by state law;

12. acknowledge receipt of:

- Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare,*
- the *Outline of Coverage,* and
- a copy of this Application — ☐ Section 1 and ☐ Section 2 (if applicable).

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (Required)

Applicant's Signature	*Date of Signature*

Section 1h: Policy Issuance

eDelivery: Email is the fastest, easiest way to get important information about your Medicare Supplement plan.

By giving my email address (print email): _____

I agree to receive electronically:

- **General information about my benefits, health programs and other services offered by Anthem that are available to me**
- **Important Plan documents, such as my Welcome Kit (including my Plan Policy), Renewal Notices (including upcoming premium changes), and Medicare's annual Notice of Change (includes upcoming changes to Medicare amounts)**
  - ☐ No thanks, I prefer to get my Important Plan Documents by paper mail.
- **Medicare Supplement Explanation of Benefits (EOBs) (claims information)**
  - ☐ No thanks, I prefer to get my EOBs by paper mail.

I understand I can change my email preference at any time by logging into my member profile at www.anthem.com or calling the customer service number on the back of my Medicare Supplement plan ID card.

IMPORTANT: This Application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in the Application.

Please do not cancel your present coverage, if any, until you receive documentation from Anthem Blue Cross, such as an ID card or written notification, showing that your Application has been approved.

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

Section 1i: Agent/Broker Information Only

Before this form can be processed the agent/broker must be appointed with us.

Agent/Broker's Printed Name: _____

Agent/Broker No.: _____

Agency No.: _____

Agency Name: _____

(Any commission will be processed using these identification numbers.)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone No.: (_____) _____

Fax No.: (_____) _____

Email Address: _____

Section 1i: Agent/Broker Information Only *(continued)*

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 certify that the applicant has read, or I have read to the applicant, the completed 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. I certify that the applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

List all health insurance policies sold to the applicant in the past five (5) years, either in force or not:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

I have requested and received documentation that indicates that the policy applied for will not duplicate any health insurance coverage. I have verified the information in the Replacement Notice section.

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

STOP

IF YOU NOTED ON PAGE 4 THAT YOU QUALIFY FOR GUARANTEED ACCEPTANCE, YOU CAN SKIP SECTION 2 OF THIS APPLICATION.

Section 2: Health History and Medical Provider Information

IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE PROVIDE COMPLETE DETAILS.

1. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility or other care facility, or do you need the assistance of a wheelchair for any daily activity? ☐ **Yes** ☐ **No**

2. Within the past two years, have you been:

a. Hospitalized two or more times, been confined to a nursing home for a total of two weeks or longer, or been to the emergency room more than three times? ☐ **Yes** ☐ **No**

b. Advised to have surgery that has not yet been done, or advised that you will need to be admitted to a hospital, skilled nursing facility or rehabilitation facility? ☐ **Yes** ☐ **No**

Section 2: Health History and Medical Provider Information *(continued)*
(If this section applies to you, answer all questions.)

3. Do you currently have or within the last three years have you been advised by a physician that you need treatment or surgery for, taken or been advised by a physician to take prescription drugs for any of the following conditions:

a. Heart conditions, **including but not limited to**, Carotid Artery Disease, heart attack, open heart surgery, heart bypass surgery, heart valve replacement, angioplasty, aneurysm, any type of heart failure or rhythm disorders, peripheral vascular disease, transient ischemic attack (TIA), stroke or placement of a pacemaker? ☐ **Yes** ☐ **No**

b. Alzheimer's disease, Parkinson's disease, multiple sclerosis, senile dementia, organic brain disorder or other senility disorder? ☐ **Yes** ☐ **No**

c. Any respiratory condition, **including but not limited to,** chronic obstructive pulmonary disease (COPD), emphysema or asthma? ☐ **Yes** ☐ **No**

d. Cancer, leukemia, Hodgkin's disease, diabetes, chronic kidney disease (including end-stage renal disease), kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, any organ transplant (except cornea), ALS (Lou Gehrig's disease), amputation, paralysis, or joint replacement due to disease? ☐ **Yes** ☐ **No**

e. Sought medical treatment or consultation for bipolar illness, major depression, schizophrenia, psychosis, alcoholism or drug abuse? ☐ **Yes** ☐ **No**

4. Have you ever tested positive for exposure to the HIV infection, been diagnosed as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ☐ **Yes** ☐ **No**

5. Are you taking any prescription medications? (provide details below) ☐ **Yes** ☐ **No**

6. In the past year, have you visited the same medical provider for 8 or more consecutive months for medical advice or treatment for the same condition? ☐ **Yes** ☐ **No**

For each question you answered "YES" above, please provide complete details below.
If additional space is needed, **attach separate sheet(s) as needed**. Remember to sign and date each sheet.
Enter dates in format: MM/YYYY and enter "Current" for any condition or medication without an end date.

Question #	**Medical Condition** (including hospitalization) and treatment date(s)	**Medication and Date(s)**	**Provider Info** (address, phone and fax numbers (including area code)
	Dates:	Dates:	
	Dates:	Dates:	
	Dates:	Dates:	
	Dates:	Dates:	

PLEASE MAKE A COPY FOR YOUR RECORDS.

Section 2: Health History and Medical Provider Information *(continued)*

Primary Physician_____

Address _____

Phone (_____) _____ FAX (_____)_____

To the best of my knowledge and belief, all information on this application, including all information provided in the Health History and Medical Provider Information section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Anthem Blue Cross determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Anthem Blue Cross with any new information that arises after the submission of this application but before my enrollment begins.

I understand that Anthem Blue Cross may need to collect personal information about me from outside sources in order to approve my Medicare Supplement Application. Personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 C.F.R. Parts 160 and 164) and state law. I also understand that under the HIPAA Privacy Regulations and state law, I have a right to see and correct personal information that Anthem Blue Cross collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem Blue Cross.

I hereby authorize, at the request of Anthem Blue Cross, any medical professional, hospital, clinic or other medical or medically related facility, government agency or other medical person or firm, to disclose information, including copies of records concerning advice, care or treatment provided to me in order for Anthem Blue Cross to review and evaluate my Medicare Supplement Application. This authorization does not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the provider's other medical records. This authorization will expire upon completion of the Application process. I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Anthem Blue Cross, P.O. Box 659816, San Antonio, TX 78265-9116.

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

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

If you are a current Anthem Blue Cross member and enrolling in a Medicare Supplement policy and have dependents that need to retain current coverage, please call the Customer Service number on the back of your ID Card. If you purchased your Anthem policy through the ACA Marketplace, you will need to call the ACA Marketplace to cancel your policy and to retain coverage for your dependents.

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

Anthem Blue Cross

P.O. Box 659816 • San Antonio, TX 78265-9116

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Anthem Blue Cross. 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 (pre-existing 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 pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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.

X _____

(Signature of Agent, Broker or Other Representative)*

Typed Name and Address of Issuer, Agent or Broker

X _____ _____

(Applicant's Signature) (Date)

*Signature not required for direct response sales

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

Anthem Blue Cross

P.O. Box 659816 • San Antonio, TX 78265-9116

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Anthem Blue Cross. 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 (pre-existing 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 pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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.

X _____

(Signature of Agent, Broker or Other Representative)*

Typed Name and Address of Issuer, Agent or Broker

X _____ _____

(Applicant's Signature) (Date)

*Signature not required for direct response sales

Medicare Supplement Insurance

Guaranteed Issue Guidelines

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116

The following situations may qualify you for guaranteed-issuance. **Please find the situation number that applies to you and note the number on the Application under the section titled *Open Enrollment/ Guaranteed Issue*.**

During guaranteed-issue periods, companies must sell you one of the required Medicare Supplement insurance policies at the best price for your age, without a pre-existing condition benefit waiting period or medical underwriting. Based on the **situation number**, your plan options may vary.

Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
# 1: You have a Medicare Advantage Plan, (like a HMO or PPO) and your plan is being discontinued or you move out of the plan's service area.	• **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends.
# 2: You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare and that plan is involuntarily ending.	• **Prior to 1/1/2020**, Plan A, F, G or N (including Innovative F). Under 65 and eligible for Medicare due to disability, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	No later than 63 calendar days after the latest of these 3 dates: • Date the coverage ends. • Date on the notice you get telling you that coverage is ending (if you get one). • Date on a claim denial, if this is the only way you know that your coverage ended.
# 3: You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. You can keep your Medicare Supplement insurance policy, or you may want to switch to another Medicare Supplement insurance policy.	• **Prior to 1/1/2020**, Plan A, F, G or N (including Innovative F). Under 65 and eligible for Medicare due to disability, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends.

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# 4: (Trial Right) You joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.	• **Prior to 1/1/2020**, Plan A, F, Innovative F, G or N. • **On or after 1/1/2020**, Plan A, G or N.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
# 5: (Trial Right) You dropped a Medicare Supplement insurance policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan less than a year, and you want to switch back.	The Medicare Supplement insurance policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If your former Medicare Supplement insurance policy isn't available, you can buy a Plan from any carrier based on when you became eligible for Medicare when turning age 65 or by disability: • **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
# 6: Your Medicare Supplement insurance company goes bankrupt and you lose your coverage, or your Medicare Supplement insurance policy coverage otherwise ends through no fault of your own.	• **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	No later than 63 calendar days from the date your coverage ends.
# 7: You leave a Medicare Advantage Plan or drop a Medicare Supplement insurance policy because the company hasn't followed the rules, or it misled you.	• **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, you have the right to enroll into Plan A, G or N.	No later than 63 calendar days from the date your coverage ends.

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# 8: You enroll in a Medicare Part D plan during the initial enrollment period, and at the time you are enrolled in a Medicare Supplement insurance policy that covers outpatient prescription drugs. You enroll into a Medicare Supplement insurance policy without outpatient prescription drug coverage.	New enrollment is permitted into a policy without outpatient prescription drug coverage by the same issuer who issued the Medicare Supplement insurance policy with outpatient prescription drug coverage. If not available by the same insurer, we offer the following plans, if you are eligible for Medicare when turning age 65 or by disability: • **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, you have the right to enroll into Plan A, G or N.	As early as 60 calendar days immediately proceeding the initial Part D enrollment period and ends on the date that is 63 calender days after the effective date of the individual's coverage under Medicare Part D.
# 9: Birthday Rule: Based on your date of birth, you can choose to change your existing Medicare Supplement plan. You can choose a plan with the same or fewer benefits as your existing plan from any company.	Any Medicare Supplement insurance policy that has the same or fewer benefits than the existing Medicare Supplement plan you are currently enrolled. *NOTE: For a coverage effective date of July 1, 2020 or later, Innovative F and standard Plan F are considered to have the same benefits when determining if a plan has the same or fewer benefits.*	No later than 30-days starting from your date of birth. For coverage effective date of July 1, 2020 or later, no later than 60-days starting from your date of birth.
# 10: Employee Welfare Benefit Plan Terminates or Changes: You are enrolled under a employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates, stops providing supplemental benefits to Medicare or stops paying the Medicare Part B 20% coinsurance.	• **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	No later than 63 calendar days from the date the employer-sponsored plan terminates or ceases, or the date you are notified of termination or cessation of all supplemental health benefits; if no notice is received, the date of the notice denying a claim due to benefit termination.

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Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
# 11: Medicare Advantage (MA) Plan Change: a) Your Anthem MA plan increased your premium or copayments, reduced your benefits, or terminated its relationship with your medical provider for reasons other than good cause relating to quality of care who was treating you. b) If the MA plan you belong to doesn't sell a Medicare Supplement insurance policy, you still have the right to buy a Medicare Supplement plan from any other company if the MA plan: (i) increased your premium or copayments by15% or more, (ii) reduced your benefits, (iii) or terminated their relationship with your medical provider for reasons other than good cause relating to quality of care who was treating you.	• **Prior to 1/1/2020**, Plan A, F or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N. Medicare Supplement enrollment is only permitted during the annual election period for Medicare Advantage.	No later than 63 calendar days from the date you are notified of any reduced benefits, increased premium or cost-sharing, or that your plan is no longer contracting with one of your medical providers. You will need to provide proof of benefit changes with your application.
# 12: You lose eligibility for full Medicaid or MediCal benefits due to an increase in income or assets and return to Original Medicare.	• **Prior to 1/1/2020**, Plan A, F, G or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	The six month period beginning on the date of the receipt of notice of loss of eligibility, or, if no such notice received, from the effective date of the loss of eligibility. You will need to provide proof of loss of eligibility.

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# 13: Military: Health care services are terminated for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.	• **Prior to 1/1/2020**, Plan A, F, G or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	The six month period beginning on the date of the receipt of notice of termination, or, if no such notice received, from the effective date of termination. You will need to provide proof of loss of coverage due to base closure, stoppage or services, or change of residence.
# 14: Divorce or Death of Spouse: Loss of eligibility due to divorce or death of spouse from any employer-sponsored health plan (including retiree, COBRA or Cal-COBRA).	• **Prior to 1/1/2020**, Plan A, F, G or N (including Innovative F). • **On or after 1/1/2020**, Plan A, G or N.	The six month period beginning on the date of the receipt of notice of termination, or, if no such notice received, from the effective date of termination. You will need to provide proof of loss of coverage.

Anthem

Premium Payment Form for Medicare Supplement and Anthem Extras Packages

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116 • Fax: 1-844-236-7967

Simplify Your Life! It saves you valuable time and money.

When enrolling in a Medicare Supplement plan, sign up for monthly Automatic Bank Draft (ABD) and save $2 per month. Drafts are made to your account on the 6th day of the month.

To ensure proper payment setup, this form MUST be returned with your Application.
Please print and use black ink.

Please print your name as it appears on your Medicare card.	Medicare Number:

I understand that the premium I have selected to pay through ABD is for my:

☐ Medicare Supplement plan ☐ Anthem Extras plan

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your premium billing preference selection does not guarantee your premium for any specific time period.

Banking Information for ABD Withdrawals

(See next page for help locating bank routing and account numbers. To ensure proper set-up, please include the routing number from a check and not a deposit slip.)

Account to deduct premium from:

☐ Personal checking ☐ Business checking Start date: _____ / _____ / _____

☐ Personal savings ☐ Business savings

Account holder name(s)	Name of financial institution
Bank Routing/Transit Number (9 digits) ☐☐☐☐☐☐☐☐☐	Bank Account Number

Automatic Bank Draft Payment: I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium(s), and the designated financial institution named above to debit the same account.

I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Anthem when set up, I authorize my bank to draft both the past due premium along with current premium(s) to ensure my coverage stays in effect. I understand if changes I make to my plan impact my auto withdrawal amount and the change occurs close to the auto withdrawal date, Anthem may not be able to notify me of the new auto withdrawal amount before the withdrawal is made. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

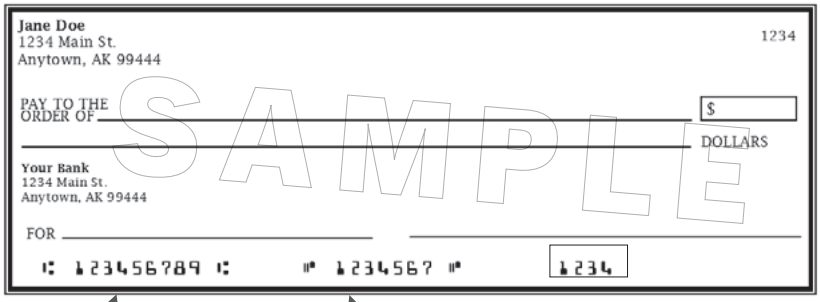
Banking Information *(continued)*

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception:** In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Anthem and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction.

Return this authorization as indicated above. **No service fees apply when paying by ABD.**

Account holder's signature (as it appears on your bank account)*	Date
X	

To find the Bank Routing and Account Numbers:



Routing Number

*(9-digits: Be sure to use the routing number from an actual check. **Do not use** the routing number from a bank deposit slip.)*

Account Number

(Sometimes the check number and Account Number are reversed.)

Check number

(Do not include the check number as part of the Routing or Account Number.)