

To Complete Your Enrollment Form:

1. Be sure to complete all information on the form, sign the form, and date the enrollment form.
2. If you would like the convenience of having your premium deducted from your Social Security check, be sure to check “Yes” in Step 5. If you want to use our other convenient payment options, complete the “Automatic Payment” information included with the enrollment form.
3. Return the form(s) by mail to:




Bill Lorenz
1300 Park Newport, Ste 415
Newport Beach, CA 92660

Or you can fax complete application to Fax: (949) 203-8786

Medicare Prescription Drug Plan Individual Enrollment Form — 2009

Be sure to complete all four pages of the enrollment form and return it to

Bill Lorenz 1300 Park Newport, Ste 415 Newport Beach, CA 92660 or by FAX 949-203-8786

Step 1: Please provide information about you. (Please print clearly.)																																										
Last Name			First Name			Middle Initial																																				
Permanent residence street address (cannot use P.O. Box)				City		County																																				
State	ZIP Code	Phone No. () ()	Alternate Phone No. () ()	Social Security No. (optional)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth																																			
Mailing/Billing Address (if different from address above)				City		State	ZIP Code																																			
Step 2: Please select a Benefit Plan — Choose only one.																																										
<p>Note to Applicant: For information about the service areas and the premiums of the Medicare Prescription Drug Plans available to you, please refer to the Summary of Benefits enclosed with your enrollment materials.</p> <p><input type="checkbox"/> Blue Cross MedicareRx Value <input type="checkbox"/> Blue Cross MedicareRx Plus <input type="checkbox"/> Blue Cross MedicareRx Gold</p>																																										
Step 3: Please provide your Medicare Insurance information.																																										
<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> • Please fill in the blanks at right so they match your red, white and blue Medicare card. <p>-or-</p> <ul style="list-style-type: none"> • Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan. →</p>				<table border="1" style="width:100%; border-collapse: collapse;"> <tr style="background-color: #cccccc;"> <td colspan="2" style="text-align: center;">MEDICARE</td> <td style="text-align: center;"></td> <td colspan="2" style="text-align: center;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="5">Name _____</td> </tr> <tr> <td colspan="3">Medicare Claim Number _____</td> <td colspan="2">Sex _____</td> </tr> <tr> <td colspan="5">_____ - _____ - _____</td> </tr> <tr> <td colspan="3">Is Entitled To:</td> <td colspan="2">Effective Date:</td> </tr> <tr> <td colspan="3">Hospital (Part A)</td> <td colspan="2">_____</td> </tr> <tr> <td colspan="3">Medical (Part B)</td> <td colspan="2">_____</td> </tr> </table>				MEDICARE			HEALTH INSURANCE		Name _____					Medicare Claim Number _____			Sex _____		_____ - _____ - _____					Is Entitled To:			Effective Date:		Hospital (Part A)			_____		Medical (Part B)			_____	
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Hospital (Part A)			_____																																							
Medical (Part B)			_____																																							
Step 4: Please answer the following questions to help Medicare coordinate your benefits.																																										
<p>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 you have other prescription drug coverage in addition to Blue Cross MedicareRx? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage.</i></p> <p>Name of other coverage _____</p> <p>ID number _____ Group number _____</p> <p>2. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes," please provide the following:</i></p> <p>Name of Institution _____</p> <p>Address and phone no. of Institution _____ / (_____) _____</p>																																										

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al número telefónico que se muestra en el material adjunto. C0003_08_008 07/2007

Office Use Only: Date Stamp

Step 5: Paying Your Plan Premium.

If you are enrolling in a plan with a monthly premium, how would you like to pay future plan premiums? You can pay your monthly plan premium by mail or by automatic checking account deduction. You might also be able to pay your premium by automatic deduction from your Social Security Check each month *(see below)*.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or some portion of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Please choose one of the payment options below: *(If no option is chosen, you will receive a monthly bill for the amount due.)*

- Send me a bill each month.
- Deduct my premium from my bank account each month. *(Depending on when you apply, more than one month's premium might be deducted for your first payment.) Please complete steps 1, 2 and 3 below:*
 - 1) Account type: Checking: Enclose a VOIDED check
 - 2) Please complete the following information for your account:
 Account Number: _____ Account Holder Name: _____ Bank Name: _____
 Bank Routing Number: _____ *(This is the first 9 digits printed on the lower left corner of your check.)*
 - 3) I authorize the bank above to allow this deduction of my monthly premium from the account above.
- Deduct my premium from my Social Security benefit check each month. *(If you choose this option, your monthly Social Security check should be at least 3 times your monthly premium. The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)*

Step 6: Attestation of Eligibility for an Enrollment Period.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Open Enrollment Period (AEP) from November 15 to December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period — you may be newly eligible for Medicare (in your Initial Enrollment Period, or IEP), or you may be eligible for a Special Enrollment Period (SEP).

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.

- I am enrolling during the Annual Open Enrollment Period from November 15 to December 31. (AEP)
- I am newly eligible for Medicare. (IEP)
Eligibility Date: ____/____/____
Mo. Day Year
- I recently moved and this plan is a new option for me.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. (SEP)
- I live in a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)
- I recently moved out of a Long-Term Care Facility (such as a nursing home or other long-term care facility). (SEP)
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). (SEP)
- I recently moved outside of the service area of my current Medicare prescription drug plan. (SEP)
Date of move: ____/____/____
Mo. Day Year
- I recently returned to the United States after living permanently outside of the U.S. (SEP)
- I belong to a pharmacy assistance program provided by my state. (SEP)
- I receive extra help to pay for Medicare prescription drug coverage. (SEP)
- I am no longer eligible for extra help to pay for my Medicare prescription drug coverage. (SEP)
- I recently left a Program of All-inclusive Care for the Elderly (PACE). (SEP)
- I am involuntarily losing coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*
- I am voluntarily leaving coverage I had from an employer or union. (SEP) *Attach copy of coverage termination letter.*
- I am eligible to disenroll from my Medicare Advantage plan and enroll in a Part D plan during an MA Open Enrollment Period or during a trial period. (SEP) Provide beginning and end dates of eligibility period: ____/____/____
- None of these statements applies to me.*

* To see if you are eligible to enroll, please contact us at the telephone number for Prospective Members shown in the enclosed Summary of Benefits.

If you qualify for an SEP and want a future effective date, please request here: Mo. ____ / Day **01** / Year ____

Step 7: 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 as part of your Medicare Advantage plan. If so, by joining Blue Cross MedicareRx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug benefits. 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 Blue Cross MedicareRx could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue Cross MedicareRx may change how your current coverage works. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Step 8: Please indicate if you prefer information in another language or format.

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

- In Spanish. (To see if materials in Spanish are available for your plan, please call Customer Service at the phone number shown in the enclosed Summary of Benefits.)
- In large print

If you need more information about materials in a format other than shown above, call Customer Service at the phone number shown in the enclosed Summary of Benefits.

Step 9: Application Agreement. *Important: Read this information before signing in Step 10.*

By completing this enrollment application, I agree to the following: The plan I am applying for is a Medicare Part D 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 coverage. I am responsible for informing Anthem Blue Cross (Anthem) 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 this plan will end my enrollment in my current plan. 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 (November 15 – December 31), unless I qualify for certain special circumstances.

This plan I am applying for serves a specific service area. If I move out of the area that this plan serves, I need to notify Anthem so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access Blue Cross MedicareRx benefits, except under limited, non-routine circumstances when I cannot reasonably use Blue Cross MedicareRx network pharmacies. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. When I receive the Evidence of Coverage document from Anthem, I will read it so I know the rules I must follow in order to receive coverage in this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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, in the future.

I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Gold Plan Members Only: By joining the Blue Cross MedicareRx Gold Plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with Anthem, he/she may be compensated based on my enrollment in Blue Cross MedicareRx. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Step 9 continues on next page.

