Click to Print

Home

Simple Instructions

1. **Print and complete the application**

2. **Include a voided check**

3. **Fax or mail your application to:**

Fax: 1-800-501-9222

or

Mail: For free postage, cut and paste this label onto your envelope.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 679 NORTHRIDGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

HEALTH AND LIFE INSURANCE SERVICES
APPLICATION PROCESSING CENTER
9510 SYLVIA AVENUE
NORTHRIDGE, CA 91324-9904

Questions? Call: 1-800-243-8100

Anthem Blue Cross
Health. Join In.℠

Anthem Blue Cross
Medicare Supplement Application — California

☐ New Enrollment ☐ Change to Enrollment

Fax to: 1-800-501-9222

Send no money now! *For assistance please contact us at 1-800-243-8100 or contact your Anthem Blue Cross Insurance Agent. To be considered for coverage, you must live in California.*

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

Last Name	First Name	MI	Sex ☐ M ☐ F	Age

Home Street Address	City	County	State	ZIP Code

Social Security Number	Date of Birth	Home Phone Number	E-mail Address (optional)
__ __ __ | __ __ | __ __ __ __	__ __ | __ __ | __ __ __ __	( )	

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

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____
MONTH/YEAR

Medical (Part B) Effective Date: _____
MONTH/YEAR

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

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 Medicare Supplement Identification Number _____

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

Section C: Plan Chosen (Check only one plan under 1 or 2 below.)

1. Are you age 65 or over OR turning 65 in the next 3 months? ☐ Yes ☐ No
If "yes," the following plan(s) are available to you:

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

2. Are you under age 65 and eligible for Medicare due to a disability? ☐ Yes ☐ No

If "yes," only the following plan(s)* are available to you:

☐ Plan A ☐ Plan F ☐ High Deductible Plan F ☐ Plan N

**Please note that individuals who have been diagnosed with End Stage Renal Disease do not qualify for either of these plans.*

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 D D 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 6th day of the month, from ☐ Checking or ☐ Savings account
NOTE: *For Automatic Bank Draft, please complete the enclosed Premium Payment Form*.

☐ Credit card (*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: Preferred Language

As part of the California language assistance regulation (California Code of Regulations, Section 1300.67.04), Anthem Blue Cross is required to develop a demographic profile of its membership. The regulation specifically includes preferred spoken and written language as part of the information needed to develop a demographic profile. If you would like to assist us in our Language Assistance Program (part of our participation in the California language assistance regulation), please complete the two questions below.

Important: **Completing these questions is strictly voluntary. The information you provide will not be used in determining eligibility or insurability.**

To find the codes needed to answer the two questions below, please see the Optional Language Coding Sheet, enclosed with this enrollment form. For each question, find the appropriate code in the numbered section on the coding sheet and write it below.

Examples: If you prefer to speak ***Cantonese***, please use "W02" to complete Question 1. And if your preferred written language is ***Chinese***, please use "ZHO" for Question 2.

1. What is your preferred spoken language? section 1 - Code: _____
2. What is your preferred written language? section 2 - Code: _____

For each question, be sure to choose the code most appropriate for you. The codes that are **printed in bold** are more general categories. Only use a code in bold if none of the other categories apply to you.

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

- Anthem Blue Cross ("the company") will not reject my application if (1) my coverage will start within 6 months of my 65th birthday, or (2) my coverage will start when I am age 65 or older and within 6 months of my Medicare Part B coverage start date, or (3) I am under age 65 and applying when first eligible or (4) I qualify for guaranteed-issue coverage for another reason. If my application is not received under one of those situations, the company has the right to reject my application. If the company rejects my application, I will be notified in writing. I understand and agree that if the company rejects my application, under no circumstances will any company benefits be payable.
- The company may request additional information, which may delay processing of this application. If the health care provider bills for this information, I understand that I may be responsible for the fee.

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 Medi-Cal or Medicaid and may not need a Medicare Supplement policy.

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 or Medicaid, for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days 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 Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling servcies may be obtained from the California Department of Aging.

(continued)

Section G: Conditions of Application *(continued)*

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 Medi-Cal 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.]

   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.

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

GUARANTEED ISSUE RIGHTS NOTICE: Before answering any Health History or Medical Information Questions, please read this important information regarding Medicare Supplement Guaranteed Issue rights.

You are not required to provide health information during a period of guaranteed issuance. You are not required to answer the Health History or Medical information questions in this application if you are entitled to a guaranteed issue Medicare Supplement Plan. If you qualify for enrollment on the basis of guaranteed issue, you will not be denied coverage.

We require applicants to sign an authorization requested by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to use or obtain medical information; however, if you qualify for Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan, you will not be required to sign that authorization.

Please refer to the **Medicare Supplement Guaranteed Issue Guideline** provided with this application to determine if you qualify for Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan.

If you think you qualify for guaranteed acceptance into an Anthem Blue Cross Medicare Supplement Plan, write the number of your qualifying situation, as described in the Guideline, in the Box below and sign where indicated.

I have read and I understand the Medicare Supplement Guaranteed Issue Guideline, which was provided to me with this application. I believe that I qualify for guaranteed acceptance based on situation number: ☐ I have attached proper documentation, if necessary, to validate my eligibility for guaranteed acceptance.

Signature: X_____ Date:_____

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

If you do not qualify for enrollment on the basis of guaranteed issue, you must complete the questions below.

Note: If the answer to any of the following questions is "yes," you might not be eligible for coverage.

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 hospitalized two or more times or been confined to a nursing home for a total of two weeks or longer? ☐ Yes ☐ No
3. Within in the past two years, have you been advised to have surgery that has not yet been done? ☐ Yes ☐ No
4. Within the past five years, have you been told you had, been consulted for treatment of, sought treatment for, had treatment recommended for, received treatment for, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for any of the following conditions:
   a. Heart conditions, including but not limited to, heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, peripheral vascular disease, heart rhythm disorders, transient ischemic attack (TIA) or stroke? ☐ Yes ☐ No
   b. Alzheimer's disease, Parkinson's disease, 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) or emphysema (excluding allergies and asthma)? ☐ Yes ☐ No
   d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, chronic kidney disease (including end-stage renal disease), kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, any organ transplant (except cornea), amputation or joint replacement due to disease? ☐ Yes ☐ No
5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No

(continued)

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

If you are not taking any medications, please check here: ☐ I am not taking any medications.

If you answered "YES" to any of the questions above, or if you are taking any medications, give complete details (see the example below as a guideline). If additional space is needed, attach separate sheet.

Item #	Specific illness, injury, procedure, surgery, hospitalization or condition	Name of Medication and Dates of Use	Name, Address, Telephone (w/area code), and Fax for Doctor	Dates of illness, injury, procedure, surgery, hospitalization or condition	
				Begin	End/Current
Note: This row is an example of how to complete this section. Please begin with next row.					
4a	Congestive Heart Failure	Lanoxin 1/2001 7/2005	Dr. John Doe 10 High Street, Suite 45 Anywhere, US 19222 1-555-555-1000 (phone) 1-800-555-2000 (fax)	11/1999	7/2005

Name of Primary Care Physician: _____ Telephone (_____) _____

Address: _____

Section I: 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, 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 individual health policy and wish to cancel that policy when this Medicare Supplement Application is approved and I become enrolled.

Policy Number: _____

(continued)

Section I: Authorizations and Agreements *(continued)*

If your present Anthem Blue Cross 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 63 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 if I incur an illness or change in medical condition during the time between the date I sign this application and the effective date of coverage, I must notify Anthem Blue Cross in writing of any such illness or change, and such notice shall be a condition of my coverage. (This does not apply if I am applying during my open enrollment period or qualify for guaranteed-issue coverage for another reason.)

I, the applicant or my authorized representative, understand that Anthem Blue Cross 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 automatic debit process and will only occur each time I send a check to Anthem Blue Cross. 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 have left nothing out regarding my past or present health. 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 regarding my past or present health conditions.

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.

(continued)

Section I: 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, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

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, PO Box 9063, Oxnard, CA 93031-9063

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:

		
Print Applicant's Name	*Applicant's Signature*	*Date*

Name of the other person or persons authorized to receive my PHI:

Name of Authorized Person	*Relationship to Applicant*

X	
Applicant's Signature	*Date*

A photocopy of this authorization is as valid as the original, and I and my Anthem Blue Cross agent or broker are entitled to receive a copy of this form after I sign it.

Notice: California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining health insurance coverage.

Section J: Binding Arbitration

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES 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, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature (Required) X _____ _____

Applicant's Signature *Date of Signature*

Section K: 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 I. 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.

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 or credit card for payment purposes, be sure to complete the ***Premium Payment Form***.

Please mail or fax 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 directly?

Mail or Fax to:

Health And Life Insurance Services
Application Processing Center
9510 Sylvia Ave
Northridge, CA 91324-1752

Fax to 1-800-501-9222

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 L: 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.: 954657410E Agent/Broker No.: _____

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

Agent/Broker's Printed Name: _____ Phone No. (_____)_____

Fax No. (_____)_____ E-mail address: _____

Street Address _____

_____

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 of up to ten thousand dollars ($10,000).

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 to: ___ / _____ _____

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," the Medicare Supplement Guaranteed Issue Guideline and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

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

Agent/Broker: Submit completed application to:

Health And Life Insurance Services
Application Processing Center
9510 Sylvia Ave
Northridge, CA 91324-1752

or Fax to 1-800-501-9222

Anthem Blue Cross
Health. Join In.℠

Medicare Supplement - Premium Payment Form

With Automatic Bank Draft, Blue Cross of California (Anthem Blue Cross) will automatically draft your premium directly from your checking or savings account.

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

Pay annually and save $48 or sign up for monthly Automatic Bank Draft and save $2 per month ... it is easy to sign up!

(Available on policies with an effective date on or after June 1, 2010.)

Full Name (please print):		**Phone**	
Mailing Address (include Apt #):	**City**	**State**	**ZIP**
Billing Address (if different than above)	**City**	**State**	**ZIP**

☐ EXISTING MEMBER (Changing Payment Option to Automatic Bank Draft)

Anthem Blue Cross Identification Number (as shown on ID card): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set-up Automatic Bank Draft for your premiums.) For existing members, return this form to: Anthem Blue Cross, P.O. Box 9063, Oxnard, CA 93031-9063.

☐ NEW APPLICANT (Initial Submission of a Medicare Supplement Application)

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 or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you.* ***To ensure proper payment setup, this form MUST be returned with your application.*

Deduct Premium: ☐ Initial Payment by Automatic Bank Draft ☐ Initial and Recurring Payments by Automatic Bank Draft ☐ Recurring Only (Initial Payment by other method)

Initial Payment by Credit Card: I wish to pay my initial* payment by Credit Card. If your application is accepted, you will be billed for any future payments unless you sign up for Automatic Bank Draft for Recurring Payments. (***Initial Payment** includes Annual Billing on the Application. If you select, Annual Billing we will charge your credit card for premium from the coverage effective date through the policy renewal date.)

Cardholder Name*: _____ Type of Credit/Debit Card: ☐ VISA ☐ MasterCard

* Full name as it appears on the card (First, Middle/MI, Last)

Credit Card Number: _____ _____ _____ _____ Expiration Date (MM/YYYY): _____/_____

Cardholder Address (if different than above): _____

BANK INFORMATION

Deduct Premium From: ☐ Checking Account ☐ Savings Account **Start Date:** _____/____/_____

Is this a business account: ☐ Yes ☐ No

Account Holder Name(s):

Name of Financial Institution:

Bank Routing/Transit Number (9 digits)	Bank Account Number
_ _ _ _ _ _ _ _ _	_____

Credit Card Payment: I authorize the Company to charge my credit/debit card for the amount specified above. By signing this form, Applicant represents and warrants that he/she has the cardholder's authorization to use the card and, if not, will take full responsibility for the payment and any charges accruing to it.

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

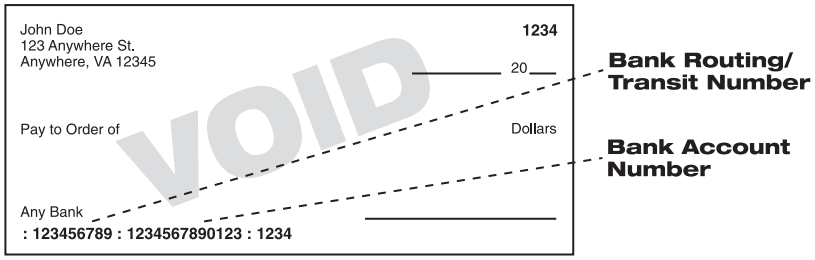
I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Anthem Blue Cross when set up, I authorize my bank to draft both the past due premium along with current premium to ensure my coverage stays in effect. If I close this account, 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.

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 Blue Cross 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 and that I will not receive a bill.

Return this authorization as indicated above. **No service fees apply when paying by Automatic Bank Draft.**

Account Holder's Signature (as it appears on your bank account)	**Date**
X	

Refer to the image below to identify where to locate the Routing Number and Bank Account Number. Do not include the check number as part of the Routing or Account Number



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

M0013_07_079 05/2007

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

Anthem Blue Cross
PO Box 9063, Oxnard, CA 93031-9063

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

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales.