Anthem

# Application for Medicare Supplement and Anthem Extras – California

Do you currently have an Anthem Medicare Supplement Plan? ..... ☐ Yes ☐ No

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

## SECTION 1

### 1A. Applicant information (Use black ink and print your name as it appears on your Medicare ID card.)

| 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 | | |
| Email address | | | |

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

### 1B. Eligibility and plan choice

If applying due to a **Guaranteed Issue** situation, see the **Guaranteed Issue (GI) Guidelines,** attached to this application for your plan options. Timeframe to enroll may be limited.

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.*

**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

Check whether you are in Open Enrollment, a Guaranteed Issue situation or are a Medicare qualified individual under the age of 65, then make your plan selection:

**A. Open Enrollment:** ☐ Turning age 65 **OR** ☐ Enrolling in Medicare Part B for the first time



**PLEASE MAKE A COPY FOR YOUR RECORDS.**

## 1B. Eligibility and plan choice *(continued)*

B. ☐ **Guaranteed Issue situation #**_____ (verify your plan options in the GI Guidelines)

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

✔ After choosing your plan, if you **checked A or B** above you can **PROCEED TO Section 3.**

✖ If you **did not** check **A or B** above, you will need to **PROCEED TO Section 2.**

C. **Medicare Eligible:** ☐ **Under age 65 and within six (6) months** of enrollment into Medicare Part B. If you are outside the six (6) months, you are not eligible to enroll.

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

- Describe the health condition that qualified you for Medicare early: _____

_____

- Do you have End-Stage Renal Disease (ESRD)? ..... ☐ **Yes** ☐ **No**
  (If you answered YES to the ESRD question above, you do not qualify.)

✔ After choosing your plan **PROCEED TO Section 3**.

➔ 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.

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

** You may enroll in Plan G only if you first became eligible for Medicare on or after January 1, 2020.

## SECTION 2: MEDICAL QUESTIONS

### 2A. Health history and medical provider information

**COMPLETE THIS SECTION ONLY WHEN YOU ARE NOT IN YOUR OPEN ENROLLMENT PERIOD OR WHEN YOU ARE NOT ELIGIBLE FOR GUARANTEE ISSUE**. Please provide complete and accurate answers to the questions. Failure to provide complete and accurate information in any part of this application may result in future denial of benefits or rescission of coverage.

If you answer **"Yes"** to any of the following questions (in **Section 2A**), you are **NOT eligible** at this time to enroll. If your health status changes in the future allowing a "No" response to the questions, please submit a new application.

**1.** Are you currently bed ridden, hospitalized, in a nursing or assisted living facility and require help with activities of daily living (ADL), receiving home healthcare, or using supplemental oxygen? (ADL includes bathing, transferring, toileting, eating, dressing, or dependent on a wheelchair or other motorized mobility device.) ..... ☐ **Yes** ☐ **No**

**2.** In the past 12 months have you been admitted to a hospital, skilled nursing facility, or rehabilitation facility or advised to have surgery, treatment or testing? (Treatment includes but is not limited to joint replacement, organ transplant, surgery for cancer, back or spine surgery, heart or vascular surgery, medical treatment that would require an inpatient admittance.) ..... ☐ **Yes** ☐ **No**

**3.** At any time have you been medically diagnosed, been treated, taken medications, or had surgery or any kind of treatment recommended for any of the following:

**A.** Diabetes that requires use of insulin, or with any complications including uncontrolled blood sugar, history of stroke, TIA, heart attack, neuropathy, renal insufficiency, or retinopathy ..... ☐ **Yes** ☐ **No**

## 2A. Health history and medical provider information *(continued)*

**B.** Chronic Kidney Disease, kidney/renal failure, kidney/renal dialysis, End Stage Renal Disease (ESRD), cirrhosis or necrosis of the liver, any organ transplant except cornea ☐ **Yes** ☐ **No**

**C.** Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Fibrosis, Cystic Fibrosis ☐ **Yes** ☐ **No**

**D.** Congestive Heart Failure, cardiomyopathy, unoperated aneurysm, heart Pacemaker, defibrillator ☐ **Yes** ☐ **No**

**E.** Cerebral Palsy, Myasthenia Gravis, Muscular Dystrophy, Multiple Sclerosis, Parkinson's, Lou Gehrig's Disease (ALS), Alzheimer's Disease, Dementia, Organic Brain Disorder ☐ **Yes** ☐ **No**

**F.** Multiple Myeloma, Lymphoma, Leukemia, Non-Hodgkin's or Hodgkin's Disease, had Chemotherapy, Blood Coagulation Defect, Hemophilia ☐ **Yes** ☐ **No**

**G.** Any acquired immune deficiency disorder (AIDS), AIDS-Related Complex (ARC), or HIV positive? (*California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining health insurance coverage.) ☐ **Yes** ☐ **No**

**4.** Within the past 12 months has a medical professional advised or recommended that you have treatment, further diagnosis, therapy, diagnostic testing, or surgery (to include joint replacement surgery), that has not yet been performed, or do you have any pending test results? ☐ **Yes** ☐ **No**

If all questions are answered **"No,"** please continue to **Section 2B**.
**REMINDER:** If you answered **"Yes"** to any of the questions above, you are **NOT** eligible to enroll at this time.

## 2B. Health history and medical provider information *(continued)*

Complete this section only if you answered "No" to every question in **Section 2A.**

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

**2.** **<u>In the past 3 years (36 months),</u>** have you been medically diagnosed, treated or advised to have treatment for, tests, surgery or prescription medications for any of the following? Please answer "yes or no", and **if "yes",** provide details under **Question 6**.

**A.** Internal cancer, carcinoma, melanoma or radiation therapy ☐ **Yes** ☐ **No**

**B.** Alcoholism, drug abuse, or Schizophrenia ☐ **Yes** ☐ **No**

**C.** Heart attack, heart bypass, Ventricular Fibrillation, Atrial Fibrillation (AFib), Peripheral Vascular Disease, stroke, Transient Ischemic Attack (TIA), aneurysm repair, valve replacement, angioplasty, stent ☐ **Yes** ☐ **No**

**D.** Rheumatoid Arthritis, Lupus ☐ **Yes** ☐ **No**

**3.** Within the last 3 years have you been hospitalized, treated at an outpatient facility, or emergency room. **If yes,** provide details to include the medical diagnosis or condition, date, treatment received, including any medications prescribed and any further treatment needed, under **Question 6**. ☐ **Yes** ☐ **No**

## 2B. Health history and medical provider information *(continued)*

**4.** Provide a list of any other medical conditions you have. Include details of treatment or surgery received, needed or recommended, any tests performed or recommended, and any medications currently taken or recommended, under **Question 6**.

**5.** List any physicians you've seen in the past 24 months under **Question 6**.

**6.** Please use the table below to provide additional details to any "yes" answers in **Section 2B**, **(Questions 2, 3, 4 and 5)** above.

| **Question #** | **Medical condition #1** | | |
|---|---|---|---|
| Treatment dates | From _____ / _____ / _____ | To _____ / _____ / _____ | |
| Medication(s) | 1. | 2. | 3. |
| Treating physician | | | |
| **Question #** | **Medical condition #2** | | |
| Treatment dates | From _____ / _____ / _____ | To _____ / _____ / _____ | |
| Medication(s) | 1. | 2. | 3. |
| Treating physician | | | |
| **Question #** | **Medical condition #3** | | |
| Treatment dates | From _____ / _____ / _____ | To _____ / _____ / _____ | |
| Medication(s) | 1. | 2. | 3. |
| Treating physician | | | |

**Use an additional sheet of paper to provide any additional information not previously disclosed.**

Primary physician_____

Phone ( _____ ) _____ Fax ( _____ )_____

## 2B. Health history and medical provider information *(continued)*

**7.** Please list any **additional medications** you have been prescribed to take, which have not been previously listed or disclosed on this application. List for what medical condition and the dates you started taking the medications, including injectables, and how often you take the medications.

| Medication #1 | | Frequency | Dosage |
|---|---|---|---|
| | | | |
| **Medication start date** | **Reason for medication (diagnosis)** | | |
| | | | |

| Medication #2 | | Frequency | Dosage |
|---|---|---|---|
| | | | |
| **Medication start date** | **Reason for medication (diagnosis)** | | |
| | | | |

| Medication #3 | | Frequency | Dosage |
|---|---|---|---|
| | | | |
| **Medication start date** | **Reason for medication (diagnosis)** | | |
| | | | |

**Use an additional sheet of paper if needed.**

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.

## 2B. Health history and medical provider information *(continued)*

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.

☐ I give Anthem consent to contact me at the email address provided in **Section 1A** for questions related to my medical conditions.

| **Signature of applicant, or authorized representative (if applicable)*** | Date |
|---|---|
| ✕ | |

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

## SECTION 3

## 3A. How do you wish to pay your premium? (SEND NO MONEY NOW!)

**Automated bank draft**

☐ I would like my payment to be deducted automatically.

➔ My **Premium Payment Form** will be attached to this application.

**Paper bill** (Using billing address in **Section 1A**)

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

**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 (or application date): _____

## 3B. 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 in **Section 1B** of this 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
☐ Premium
☐ Premium Plus
☐ Premium Plus Dental (**only**)

## 3B. Anthem Extras Packages (optional benefits – additional premiums apply) *(continued)*

**Billing/payment options:**

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

Select One: ☐ Paper statement (mailed to **billing address** in **Section 1A**)

☐ Automatic bank draft (premium deducted same day as your effective date – **Premium Payment Form required)**

## 3C. 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 plan 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.

## 3C. 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 plan 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? _____

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**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**

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**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 "START" and expected "END" Date?

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

## 3C. Other coverage information *(continued)*

**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

## 3D. 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 six-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

**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;

## 3D. Authorizations and agreements *(continued)*

**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

**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 of applicant, or authorized representative (if applicable)* | Date |
|---|---|
| ✕ | |



*(continued)* ▶

## 3E. Policy issuance Email is the fastest, easiest way to get important plan information.

**I agree to receive electronically the following materials based on my email address provided in Section 1A:**

- ✔ **General information about my benefits, health programs and other services offered by Anthem that are available to me**
- ✔ **Important Plan documents:**
  - **Medicare's annual Notice of Change (includes upcoming changes to Medicare amounts)**
  - **Welcome Kit (including my Plan Policy)**
  - **Renewal Notices (including upcoming premium changes)**
  - ☐ 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 secure 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 this 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.**

***SEND NO MONEY NOW — PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.***

| Signature of applicant, or authorized representative (if applicable)* ✖ | Date |
|---|---|
| | |

*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).

## SECTION 4: AGENT/BROKER ONLY

### 4A. Agent/broker information

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

Agent/broker's printed name: _____

Agent/broker #: _____

Agency #: HKLJJJJPVY

Agency name: Nevin & Witt Insurance Services

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

Street address: 1600 Mangrove Ave. #195

City: Chico State: CA ZIP code: 95926

Phone: ( 530 ) 894-0111

Fax: ( 530 ) 203-6300

Email: info@nevinandwitt.com

## 4A. Agent/broker information *(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.

**Signature of agent/broker** ✕ | Date

**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 Plan 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 plan 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.

✖ _____

(Signature of agent, broker or other representative)*
Typed name and address of issuer, agent or broker

✖ _____ _____

(Applicant's signature) (Date)

*Signature not required for direct response sales

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.)

**Deduct premium:** Start date: _____ / _____ / _____

☐ **Monthly** ☐ **Quarterly** ☐ **Annual**

**Deduct premium from:**

**Checking:** ☐ Personal ☐ Business **– OR –** **Savings:** ☐ Personal ☐ Business

| 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.

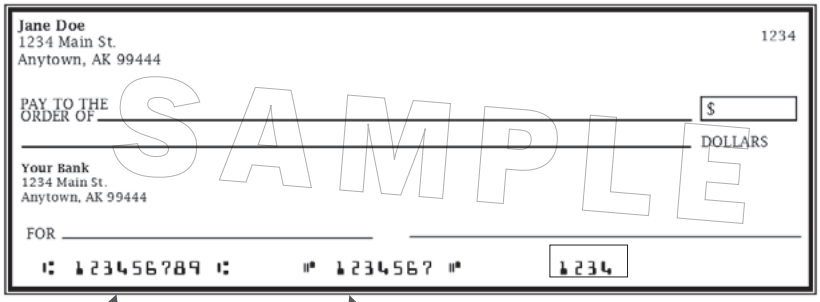
## Banking Information *(continued)*

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.)*