

Medicare Supplement

Express Application For Newly Medicare-Eligible Individuals



To use this form, you must be enrolling in Medicare Parts A and B and live within our 85-county service area in Eastern, Central and Southern Missouri. You must be turning 65 *or* first eligible for Medicare due to disability *or* first enrolling in Part B at age 65 or older. **You may not use this form if you are applying for duplicate Medicare Supplement Coverage or if you are disenrolling from a Medicare Advantage Plan.**

Section A Applicant Information (Please print. Use ink only.)					
Last name		First name		MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home address		City		State	Zip code
Social Security no.	Date of birth	Age	E-mail address (optional)	Phone no. ()	
Section B Medicare Information (This information must be provided from your Medicare card.)					
Medicare claim no. alpha ()		Hospital (Part A) effective date		Medical (Part B) effective date	
Section C Medical Plan Chosen (Check only one plan. Check one premium type, if necessary.)					
<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan F			<input type="checkbox"/> SmartChoice <input type="checkbox"/> SmartChoice Preferred (High-Deductible Plan F) (High-Deductible Plan F)		
Premium type: <input type="checkbox"/> Issue-Age or <input type="checkbox"/> Community-Rated			Premium type: Issue-Age only		
Section D Dental Coverage					
At an additional cost, do you wish to purchase optional dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (See page 4.)					
Section E Desired Effective Date					
Indicate what month you want coverage to start: / /		Unless you indicate otherwise at left, your effective date will be the first of the month after Anthem receives your completed application or approves it, if approval is necessary. Upon approval, effective date cannot be changed.			
Agent/Broker Information Only: This section is to be completed only by the agent/broker, if any, who represents the Applicant.					
Important: Before this form can be processed, the agent/broker's current Missouri health and life license must be on file with Anthem. In addition, the agent/broker must be contracted with Anthem.					
Please provide the Agency Code No. _____ and the Agent/Broker Code No. _____ that Anthem has assigned to you. (Commission will be processed using these identification numbers.)					
Agent/Broker's Printed Name: _____ and Phone No.: (____) _____					
Agent/Broker's Fax No.: (____) _____ and E-mail address: _____					
Agent/Broker's Signature: X _____ Date of Agent/Broker's Signature: X _____					
Have you previously sold the applicant any health policies still in force? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list on a separate sheet and attach.					
List all policies you sold to applicant in the past five years: _____ _____					

Section F First Payment Options (Your first month's premium **must** be submitted with your application.)

How do you want to pay your first month's premium?

- By check (Please enclose your check, made payable to Anthem Blue Cross and Blue Shield.)
- By credit card (See below.)
- By automatic bank withdrawal* (Be sure to complete the account information in Section G.)

Total premium submitted: \$ _____

If paying by credit card: A credit card can be used only for this *initial* premium payment. If your application is accepted, future payments will be billed to your address or automatically withdrawn from your bank, if you choose that option in Section G. Your credit card will not be charged for your initial payment unless you are approved for coverage.

Cardholder's Name (as shown on the credit card): _____

Cardholder's Address: _____
street address city state ZIP code

If applicant is using the credit card of another cardholder: By signing the authorization below, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of Credit Card: VISA Mastercard
 Discover American Express

Credit Card Number: _____

Expiration Date (month/year): ____ / ____

Authorization: I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount of my initial premium for the coverage selected.

Applicant's Signature:
X _____

Section G Options for Future Premium Payments

Frequency (check one): Monthly Quarterly Semi-annually Annually

How do you want to pay your future premium payments?

Send Bill: Bills will be sent to your home address unless you provide a separate billing address below.

_____ name street address city state ZIP code

Automatic Bank Withdrawal (on the fifth day of the month):* From Checking account or Savings account

If you selected automatic bank withdrawal, you must attach below a blank voided check for checking account deduction **or**, for savings account deduction, attach below a blank deposit slip showing the bank name, account holder's name and account number. If you choose savings account deduction, **verify the correct Bank Transit/ABA routing number** through your bank/financial institution.

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the account indicated and the designated financial service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.

Account holder's name (please print) _____	Account holder's signature (if other than applicant) X _____	Bank Transit/ABA routing no. _____
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* If you selected Automatic Bank Withdrawal, staple a blank voided check **or** a blank deposit slip here.

Section H

Please read these six statements. Then complete the questions below.

Important Statements:

1. You must have both Parts A & B of Medicare to enroll in a Medicare Supplement plan. You should be enrolled in only one Medicare Supplement or Medicare Advantage plan.
2. If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement plan.
4. If, after purchasing this plan, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement plan can be suspended, if requested, for 24 months while you have Medicaid benefits. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstated plan will **not** have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your prior coverage.
5. If you are eligible for, and have enrolled in, a Medicare Supplement plan 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 plan can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstated plan will NOT have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your prior coverage.
6. Counseling services are available in Missouri 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). For insurance counseling, call (573) 817-8300 or 1-800-390-3330.

Questions:

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 plan, or that you had certain rights to buy such a plan, 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. Please mark "Yes" or "No."

1. Did you enroll in Medicare Part B in the last 6 months? Yes No
If "Yes," what is your effective date? _____
2. Are you covered for medical assistance through the state Medicaid program? (Note : If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.) Yes No
 - a) If "Yes," will Medicaid pay your premiums for this Medicare Supplement plan? Yes No
If "Yes," do you receive benefits from Medicaid *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 (such as a Medicare Advantage plan, including a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End Date" blank.
Start Date ____ / ____ / ____ End Date ____ / ____ / ____

If you provided a Start Date or End Date in 3a, complete 3b,c and d, below.

3. b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan?
 Yes No
 - c) Was this your first time in this type of Medicare plan? Yes No
 - d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? Yes No
4. a) Do you have another Medicare Supplement plan in force? Yes No
 - b) If "Yes," with what company, and what plan do you have? _____

c) If "Yes," do you intend to replace your current Medicare Supplement plan with this plan? Yes No
If "Yes," state your reason for disenrollment from your current plan. _____
If "No," we cannot process this application because the law does not allow us to sell duplicate coverages.
5. Have you had coverage under any other health insurance (for example, an employer, union, or individual plan) within the past 63 days? Yes No
 - a) If "Yes," with what company and what kind of plan? _____
 - b) What are your dates of coverage under the other plan? (If you are still covered under the other plan, leave "End Date" blank.)
Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Section I Significant terms, Conditions and Authorizations

I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. I understand that Anthem reserves the right to accept or decline this application in accordance with Missouri law and that no right whatsoever is created by this application.

I understand that Anthem 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 automatic debit process and will only occur each time I send a check to Anthem. 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.

Waiting Periods for Dental coverage: If I enroll in optional Dental Blue *Senior* coverage, I understand that I will have a six-month waiting period for coverage of Basic services and a 12-month waiting period for coverage of Major services. *(For a description of Basic and Major services, please refer to your marketing materials.)*

If my request for coverage is being handled by an agent/broker, I understand that the agent/broker is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthem's other rights or requirements.

Any material misrepresentation found in this application may result in denial of benefits or rescission or cancellation of my coverage. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have received the **Guide to Health Insurance for People with Medicare**.

Applicant's signature X	Date X
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Important: This Application will not be processed unless the applicant signs above. Please do not cancel your present coverage, if any, until you receive documentation from Anthem Blue Cross and Blue Shield, such as an ID card or written notification, showing that your Application has been approved.