

Anthem use only – DO NOT WRITE IN THIS AREA

Agent use only – DO NOT WRITE IN THIS AREA

Policy ID no.		Agent name	
Assigned effective date	UW date	Agent tax ID	Agent no.
UW information			

Check one.

I am applying for: New coverage Change to my current coverage: Contract ID no. _____

Section A Applicant Information (PLEASE PRINT. USE INK ONLY.)

Last name		First name		Middle initial
Residence address			City	State ZIP code
Social Security no.	Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone no. ()

Are you a U.S. citizen? Yes No *If no, attach a copy of your green card or visa.*

Billing address information: (For premium notices If mailing address different than above)

Last name (c/o)		First name		Middle initial
Street/P.O. box			City	State ZIP code

SECTION B MEDICARE CARD INFORMATION (THIS INFORMATION MUST BE TAKEN FROM YOUR MEDICARE CARD.)

Medicare claim no. ()	alpha	Hospital (Part A) effective date	Medical (Part B) effective date
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Section C Benefit Selection: Check Plan Desired (Select only one.)

Medicare Supplement (Use any hospital) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan H	Medicare Select (where available—must use network hospitals) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan C <input type="checkbox"/> Plan F
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Section D Desired Effective Date

Indicate what month you desire coverage to start: / /	Effective dates are issued on the first of the month following the date the completed application is received by Anthem unless otherwise indicated. Upon approval, NO CHANGE to the effective date will be permitted.
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Section E Billing Information

Bill me at home: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly OR <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	Bill me through <input type="checkbox"/> Automatic Bank Draft (Your bank must be participating. Please complete Section I.)	Total premium submitted \$ _____ Make check payable to Anthem Blue Cross and Blue Shield
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Section F Other Coverage Information / Balanced Budget Act (NOTE: This information must be completed UNLESS you are turning 65 years old or are over 65 years old and first enrolled in Medicare Part B.)

IMPORTANT NOTICES:

- * You **do not** need more than one Medicare Supplement policy.
- * If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- * You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. The benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
- * 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 Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

1. Do you have another Medicare Supplement policy or certificate in force? Yes No
 If yes, with which company? _____
 If yes, do you intend to replace your current Medicare Supplement policy with this certificate?..... Yes No
If yes, complete the Replacement form.)
2. Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?..... Yes No
 If yes, with which company? _____
 What kind of policy? _____
3. Is your current coverage an Anthem Blue Cross and Blue Shield plan? Yes No
 If yes, do you intend to **replace** it with this Medicare Supplement policy? Yes No
4. Are you covered for medical assistance through the state Medicaid program? Yes No
 - a. As a Specified Low-Income Medicare Beneficiary (SLMB)? Yes No
 - b. As a Qualified Medicare Beneficiary (QMB)? Yes No
 - c. For other Medicaid medical benefits?..... Yes No

Complete the following information to determine if you qualify for coverage under the Balanced Budget Act (BBA). Provide details in the designated area for any "yes" answers. To be considered for guarantee issue coverage Anthem must receive your application within 63 days of termination of your prior coverage.

A Medicare+Choice plan is considered any of the following:

- *Medicare Health Maintenance Organization (HMO)
- *Medicare Preferred Provider Organization (PPO)
- *Medicare Physician Service Organization (PSO)
- *Medicare Medical Savings Account (MSA)
- *Medicare Health Maintenance Organization (HMO) with a Point-of-Service (POS) option
- *Medicare Private Fee for Service Plan

5. Were you enrolled under an employee welfare benefit plan that provided health benefits that are primary or secondary to Medicare, and the plan has terminated; or ceased providing supplement benefits; or have you left such Plan? Yes No
 Please explain _____
6. Has your Medicare+Choice Plan lost its certification or discontinued providing coverage in the area in which you live?..... Yes No
7. Have you moved out of the service area of your Medicare+Choice Plan or Medicare Select Plan? Yes No
8. Did your enrollment under a Medicare+Choice Plan or Medicare Select Plan cease because of insolvency of the insurer; or other involuntary termination of coverage or enrollment? Yes No
9. Is this the first time you were enrolled in Medicare Part B and a Medicare+Choice Plan or Medicare Select Plan and are disenrolling within the first 12 months of coverage? Yes No
10. Did you disenroll from a Medicare+Choice Plan or Medicare Select Plan for any other reason?..... Yes No
 State reason for disenrollment. _____

PROVIDE DETAILS HERE FOR ANY "YES" ANSWERS TO QUESTIONS 2-10 ABOVE.

Question No.	Name of plan	Type of coverage	Effective date of coverage	Termination date of coverage

Section G Medical Questions

Answer the following medical questions. NOTE: If applying during your Medicare Open Enrollment period or for guarantee issue coverage DO NOT complete these questions. **Open Enrollment begins, for a period of six (6) months, on the first day of the month in which you are turning 65 years old or are over 65 years old and first enrolled in Medicare Part B.**

1. Are you currently hospitalized, bed-ridden, or confined to a nursing facility or wheelchair? Yes No
2. Have you been hospitalized three (3) or more times in the past 12 months?..... Yes No
3. During the past five (5) years have you been treated for heart disease including Angina or Atrial Fibrillation OR been hospitalized for any heart condition or had any type of amputation caused by disease? Yes No
4. Within the past three (3)years have you been treated for or been advised to seek treatment for:
 - a. Chronic lung or respiratory condition including black lung, Chronic Obstructive Pulmonary Disease (COPD) or emphysema?..... Yes No
 - b. Alzheimer's disease?..... Yes No
 - c. Internal cancer or malignant melanoma? Yes No
 - d. Cirrhosis of the liver?..... Yes No
 - e. Mental or nervous disorder? Yes No
 - f. Kidney dialysis? Yes No
 - g. Insulin Dependent diabetes? Yes No
 - h. Stroke or Transient Ischemic Attack (TIA)? Yes No
 - i. Parkinson's disease?..... Yes No
5. Within the past two (2) years have you been advised to have surgery, treatment (excluding non-prescription drugs), or to be hospitalized or confined to a nursing facility, but not done so? Yes No
6. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or any other abnormality of the immune system, or had a positive result on an HIV test? Yes No
7. Were you eligible for Medicare before age 65? Yes No
If yes, explain disability _____
8. Are you currently taking any medications? **(Complete only if applying for Medicare Supplement Plan H.)** Yes No

Section H Medical Details (Provide complete details for questions 1 through 8 here.)

Question no.	Name of condition, illness or injury	Symptoms, details of treatment & medications	Date of diagnosis	Date last treated	Name of physician

Current Medications Taken	Why Taken

Section I Automatic Bank Draft Authorization

If you completed Section E and selected Monthly Automatic Bank Draft, please complete this section. You **MUST** attach a **blank** "voided" check for checking account deduction OR a **blank** deposit slip for savings account deduction including bank name, account holder's name and account number. If you choose savings account deduction, **verify the correct 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 institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this 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		Premium will be deducted on the fifth of the month. Deduct premium on the following basis: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually
Account holder's signature (if other than the applicant)		
Applicant's Social Security no.	Bank Transit/ABA no.	Deduct premium from: <input type="checkbox"/> Checking account <input type="checkbox"/> Savings account

If you selected Automatic Bank Draft as your method of payment, you must attach a voided check (for checking account withdrawal) or a blank savings deposit slip (for savings account withdrawal).

Attach
a blank (voided) check or
a blank savings deposit slip
here.

I may not assign any payment under my Anthem Blue Cross and Blue Shield program.

I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application.

I understand that Anthem reserves the right to accept or decline this application in accordance with Indiana law and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.

I understand that if I incur an illness or change in medical condition during the period of time between the application signature date and effective date that I must notify Anthem in writing of any such illness or change, and such notice shall be a condition precedent to coverage (this does not apply if I am applying during Open Enrollment or qualify for guarantee issue coverage.)

Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself. A photocopy is as valid as the original. I understand I may request a photocopy.

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

DISCLOSURE STATEMENT: If I am applying for a Medicare Select Plan, I understand the network restrictions of the coverage for which I've applied and I acknowledge receipt of the following:

- Outline of Coverage
- Network Hospital Directory
- Notice Regarding Replacement
- Anthem's Quality Assurance Procedures and Grievance Procedures

I indicate understanding and assent to these terms by my signature below.

Applicant Signature X	Date
Agent Signature	Date
Agent Sold Cases Only Agent shall list any other health insurance policies agent has sold to the applicant. List policies sold in the past five years which are no longer in force _____	

Do not cancel your present coverage until you receive written notification from Anthem Blue Cross and Blue Shield that your new coverage is in force.