Anthem

Application for Medicare Supplement and Georgia Extras – Georgia

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

☐ New Enrollment
☐ Change to Existing Anthem Blue Cross and Blue Shield Medicare Supplement Plan

Section 1a: Applicant Information (Please print and use black ink only.)

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) / /	Age	Home Phone Number ( )	

Language Preference (Optional): ☐ Decline

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

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

Please complete the information below using your Medicare card (include all letters and numbers).

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Medical (Part B) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Section 1b: Plan Selection

If applying due to a Guaranteed Issue situation, see **Section 1e** as your plan options may be limited.

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

I would like to apply for Medicare Supplement Plan (check only one box):

☐ Plan A* ☐ Plan F* ☐ Plan G ☐ Plan N

*If you are under age 65, eligible for Medicare due to disability and within six (6)-months of your enrollment into Medicare Part B, these Plan(s) are available to you.

Policy Effective Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Coverage is effective as of the 1st of the month following approval of your completed application. To ensure continuation of coverage, you can request an initial effective date other than the 1st of the month. The effective date must be within 180-days of application signature for guaranteed issuance applicants and 90-days for applicants subject to medical underwriting. After the initial effective date, your policy will move to a 1st of the month anniversary date.

Have you purchased a stand-alone Prescription Drug Plan (PDP)? ..... ☐ **Yes** ☐ **No**

a. If yes, with what company? _____ PDP Effective Date: ____ / ____ / _____

Section 1c: How Do You Wish to Pay Your Premium? (SEND NO MONEY NOW!)

Automated Bank Draft*

- ☐ Monthly – save $2 per month
- ☐ Quarterly
- ☐ Annual – save $48 per year

Paper Bill (Send to **Billing Address** in Section A)

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

* Please complete the **Premium Payment Form**. Drafts are made to your account on the 6th day of the month.

Household Discount Determination – Save 5%:

When more than one member in the same household enrolls in a Medicare Supplement plan with us, they may qualify for our Household Discount. If you believe you qualify for the discount please provide the following information in order for us to verify eligibility. If eligible, the discount applies to both parties.

Last Name _____ First Name _____ MI _____

Medicare Claim Number: _____

Anthem Blue Cross and Blue Shield or Blue Cross and Blue Shield of Georgia Member ID Number:

_____

Section 1d: Other Coverage Information

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 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 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? _____

2. Are you covered for medical assistance through the state Medicaid 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 Medicaid pay your premiums for this Medicare Supplement policy? ☐ **Yes** ☐ **No**

b. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

Section 1d: Other Coverage Information *(continued)*

Complete this section if you had coverage under a Medicare Supplement (Medigap) or Medicare Advantage (HMO, PPO, etc.) plan within the last 63 days.

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**

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 expected "END" Date? END _____ / _____ / _____

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 _____ / _____ / _____

Policy Number: _____ Customer Service Phone Number: _____

c. If ending, indicate reason why your coverage is ending: _____

Section 1e: Open Enrollment/Guaranteed Issue

(If applying outside a guaranteed issue period, be sure to complete and submit Section 2 of this application.)

If you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance, please identify the situation that applies:

- ☐ Turning age 65 **OR** first time enrolling in Medicare Part B (Plan Options: All Plans)
- ☐ Enrolled in Original Medicare and an employee welfare benefit plan (including retiree or COBRA coverage) or union coverage that is primary to Medicare or supplements benefits under Medicare and the plan is ending or ceases to provide the supplemental health benefits (Plan Options: A, F, G, N)
- ☐ Medicare Advantage is being discontinued **OR** you have moved out of the Medicare Advantage service area (Plan Options: A, F, N)
- ☐ Other: provide the situation from **Medicare Supplement Guaranteed Issue Guideline** that is included at the end of this application: Situation #_____

Attach required documentation to validate eligibility for guaranteed acceptance as a separate sheet, sign and date the sheet.

If you originally qualified for Medicare under age 65, please describe medical condition that qualified you:

_____

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.

Section 1f: Georgia Extras Packages (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.

These optional benefits are available to you for an **additional premium**.

If you currently have medical or dental coverage through Anthem Blue Cross and Blue Shield or Blue Cross and Blue Shield of Georgia, please provide your Identification Number: _____

If you are still covered under this plan, leave "END" blank. ..... START ____ / ____ / ____ END ____ / ____ / ___

If you are a current Anthem Blue Cross and Blue Shield or Blue Cross and Blue Shield of Georgia member, what insurance do you have with us?

- ☐ Individual Dental
- ☐ Group Dental

The **effective date** will be the same as the effective date on **page 2** of the Medicare Supplement application.

Georgia Extras Offerings:

- ☐ Standard Package
- ☐ Premium Package
- ☐ Premium Plus Package
- ☐ Premium Plus Dental (**only**)

Billing/Payment options:

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

Select One: ☐ Paper Statement (mailed to **Billing Address** in Section A)

☐ Automatic Bank Draft (Premium deducted same day as your effective date – Georgia Extras Premium Payment Form required)

Section 1g: 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 and Blue Shield 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 and Blue Shield 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 6-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;

Section 1g: Authorizations and Agreements *(continued)*

7. understand upon acceptance that my Application will become part of the agreement between the Company and myself;

8. authorize Anthem Blue Cross and Blue Shield to use and disclose my personal information when necessary for the operation of my health or other related activities and that Anthem Blue Cross and Blue Shield will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

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. acknowledge responsibility for any overdraft fees permitted by state law;

11. 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 — ☐ Section 1 and ☐ Section 2 (if applicable).

Section 1h: Policy Issuance

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 the Application.

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.

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

3. If replacing a Medicare Supplement or Medicare Advantage policy, the **Replacement Notice** is signed and dated by both you and your insurance agent (if applicable) and returned with your Application.

Please mail the entire Application (including any additional forms) to the address below:

Anthem Blue Cross and Blue Shield
P.O. Box 659816
San Antonio, TX 78265-9116

OR, fax to: 1-844-236-7967

Signature of Applicant, or Authorized Representative (if applicable)* PLEASE MAKE A COPY FOR YOUR RECORDS. **X**	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).

— SEND NO MONEY NOW —

PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.

Anthem Blue Cross and Blue Shield
P.O. Box 659816
San Antonio, TX 78265-9116
Fax: 1-844-236-7967

Premium Payment Form for Medicare Supplement and Georgia Extras Packages

With Automatic Bank Draft, Anthem Blue Cross and Blue Shield will automatically draft your premium directly from your checking account.

Full Name (please print)		**Phone**	
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**

Medicare Supplement

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 Medicare Supplement policies with an effective date on or after June 1, 2010.)

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

Medicare Supplement Identification Number (as shown on Medicare Supplement 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.) Please return this form to: Anthem Blue Cross and Blue Shield, P.O. Box 659816, San Antonio, TX 78265-9116.

Deduct Premium (select one): ☐ Monthly* ☐ Quarterly ☐ Annually*

(*Applicable discounts for monthly or annual Automatic Bank Draft are not guaranteed and are subject to change.)

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

I understand that the 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.*

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. Please refer to your *Outline of Coverage* for additional information regarding changes in Premiums.

Anthem or Georgia Extras Packages

☐ **EXISTING MEMBER (Changing Anthem or Georgia Extras Packages Payment Option to Automatic Bank Draft)**

Anthem or Georgia Extras Identification Number (as shown on Anthem or Georgia Extras ID card): _____

Billing number (starting with SR): _____

(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.)

Deduct Premium (select one): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ **NEW APPLICANT (Initial Submission of a Georgia Extras Packages Application)**

I understand that the 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.*

Banking Information For Any Medicare Supplement and Georgia Extras Packages Selected Above

BANK INFORMATION (For Existing Member and New Applicant)

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

Is this a business account: ☐ Yes ☐ No

Account Holder Name(s):

Name of Financial Institution:

(continued)

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 Blue Cross and Blue Shield or Blue Cross and Blue Shield of Georgia 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. 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 Blue Shield or Blue Cross and Blue Shield of Georgia 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**

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.