Application for Medicare Supplement and Anthem Extras – Georgia

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

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

Section 1a: Applicant Information

(Please print your name as it appears on your Medicare ID card 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)	Phone Number
/ /	( )

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

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)

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

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

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

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.

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

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

PLEASE MAKE A COPY FOR YOUR RECORDS.

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**.

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 Blue Cross and Blue Shield Member ID Number:

____

Section 1d: 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 Medicaid 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 Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid, for 24 months. 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 policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing 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).

(continued)

Section 1d: 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 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? ____________________

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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**

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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 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 _____ / _____ / ______

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

☐ Voluntary ☐ Involuntary

Section 1e: Open Enrollment/Guaranteed Issue

☐ Turning age 65 or enrolling in Medicare Part A and/or B

☐ Qualify due to a Guaranteed Issue situation. Provide **situation #**_________ from the Guaranteed Issue Guidelines included.

If you did not check one of the above boxes, you will need to complete Section 2 of the Application.

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: 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 and Blue Shield, 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 on **page 2** of the Medicare Supplement application.

Anthem Extras Offerings:

☐ Standard Package ☐ Premium Plus Package

☐ Premium 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 – **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;

(continued)

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

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 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

eDelivery: Email is the fastest, easiest way to get important information about your Medicare Supplement plan.

By giving my email address (print email): ______________________________

I agree to receive electronically:

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

  ☐ 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 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 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.

Signature of Applicant, or Authorized Representative (if applicable)*	Date
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).

Premium Payment Form for Medicare Supplement and Anthem Extras Packages

Anthem Blue Cross and Blue Shield
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.)

Account to deduct premium from:

☐ Personal checking ☐ Business checking Start date: ________ / _______ / ___________

☐ Personal savings ☐ Business savings

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.

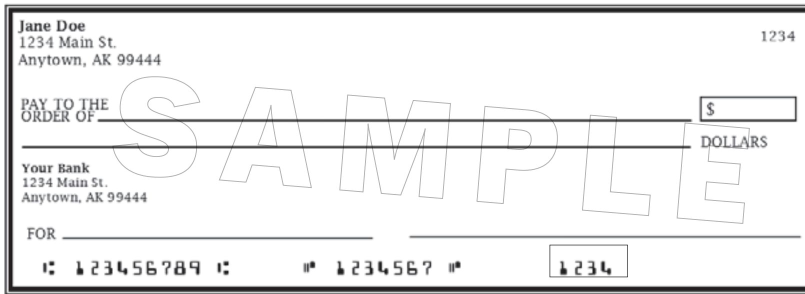
Banking Information *(continued)*

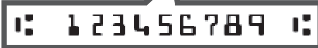
I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception:** In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if 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 and that I will not receive a bill.

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)* **X**	Date

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.)

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. (AICI). The Medicare Supplement plans are offered by AICI and the Anthem Extras Packages are offered by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.