Internal Use Only
Membership Number
Division Number
Effective Date
Check #
Amount
Batch Info/Date

Anthem.

ANTHEM INDIVIDUAL MEDICARE SUPPLEMENTAL ENROLLMENT/CHANGE APPLICATION

3000 Goffs Falls Road
Manchester, NH 03111
New Enrollment: 1-800-382-4832
Current Anthem Medicare Supplement Members: 1-800-227-4641

To Be Completed By Producer
Producer Name LINDA ALLEN
Vendor Code # N 9524

PLEASE USE BLACK OR BLUE INK ONLY

1. INFORMATION ABOUT YOU (PLEASE PRINT OR TYPE)

Name (Last/First/Middle Initial)	Social Security Number
Home Address (Number and Street)	Sex ☐ Male ☐ Female
City/State/Zip Code	Date of Birth Mo. | Day | Yr.
Billing Address (If different from home address)	Telephone Number
City/State/Zip Code	Email Address

☐ **NEW ENROLLMENT** ☐ **CHANGE**

2. SELECT YOUR MEDICARE SUPPLEMENT PLAN

Please check the **one** Anthem Blue Cross and Blue Shield policy you are applying for.

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan F ☐ High Deductible Plan F ☐ Plan J

Requested Effective Date ____________________

3. MEDICARE INFORMATION

Please give your Medicare information as shown on your red, white and blue card.

Medicare Claim Number ______________________________

Hospital (Part A) Effective Date: ______________________
MONTH/YEAR

Medical (Part B) Effective Date: ______________________
MONTH/YEAR

MEDICARE **HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER SEX
000-00-0000-A **FEMALE**
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

In New Hampshire, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc, an independent licensee of the Blue Cross and Blue Shield Association.
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4. Billing Choice (Please Check One)	☐ Monthly Electronic Fund Transfer - **complete section 5 and attach a voided check or savings account deposit slip.** ☐ Quarterly Paper Bill* ☐ Annual Paper Bill** *Quarterly billing only available on a Jan., April, July or Oct. cycle. **Annual billing is calculated on the number of months remaining in the calendar year.

5. Electronic Fund Transfer Authorization (EFT) *(This section must be completed if you want your monthly payments deducted directly from your checking or savings account.)*

I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal each month from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.

Bank Name	Phone Number
Bank Address	City/State/Zip Code
Bank Information: Routing #	Account #

Type of Account: (Check Only One): ☐ Checking Account (must attach voided check)
☐ Savings Account (must attach saving account deposit slip)

This authorization is to remain in effect until Anthem Blue Cross and Blue Shield has received at least 30 days prior written notification from me of a termination date.

6. REPLACEMENT OR OTHER COVERAGE INFORMATION

Please provide us with the following information, to the best of your knowledge:	YES	NO
(1) Do you have any other health insurance policy or certificate in force (including health care service contract, health maintenance organization or Medicare Supplement insurance contract)?	☐	☐
(a) If YES, what is the name of that company? ______		
(b) Date this coverage was effective: ______		
(c) Date this health insurance coverage will cancel: ______		
(2) If the answer to question 1 is yes, do you intend to replace your current medical health or Medicare Supplement policy with this policy?	☐	☐

If you have answered YES to questions 1-2, please read the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance, (See Section 8).

(3) **Are you covered for medical assistance through the state Medicaid program?**
Note: Medicaid is a state-administered program and is not the Medicare program.

	YES	NO
(a) As a Specified Low-Income Medicare Beneficiary (SLMB)?	☐	☐
(b) As a Qualified Medicare Beneficiary (QMB)?	☐	☐
(c) For other Medicaid medical benefits?	☐	☐

7. DID YOU KNOW?

- 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 coverages.
- 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 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted, if requested, within 90 days of losing Medicaid eligibility.
- You should have Medicare hospital (Part A) coverage and **must** have Medicare medical (Part B) coverage and be 65 years of age or be eligible for Medicare disability coverage to enroll in a Medicare supplement plan. Benefits will only be payable to supplement the Medicare Programs in which you are enrolled.
- 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). Call your local Social Security department or State Insurance Department for details.

8. NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ANTHEM BLUE CROSS AND BLUE SHIELD:

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 coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

______ Additional benefits ______ No change in benefits, but lower premiums

______ Fewer benefits and lower premiums _____ Other (Please specify) ______________________

I certify that the foregoing information is true and complete to the best of my knowledge and belief. I further understand that no benefits will apply until the coverage is made effective by Anthem Blue Cross and Blue Shield. To prevent application processing delays and/or non-payment of claims, it is recommended that Anthem receive your application in advance of the 31st of the month for coverage to be effective the 1st of the following month.

I UNDERSTAND THAT FALSE AND/OR INCOMPLETE RESPONSES OR STATEMENTS MAY RESULT IN RESCISSION OF COVERAGE AND/OR NON-PAYMENT OF CLAIMS.

I understand this application shall become a part of my request for insurance. In order to process your application accurately, Anthem may need to contact you to obtain additional information or missing information.

______________________________ ____________

SIGNATURE OF APPLICANT DATE

______________________________ ____________

SIGNATURE OF AGENT, PRODUCER OR OTHER REPRESENTATIVE DATE
(NOT REQUIRED FOR DIRECT RESPONSE SALES)

LINDA W ALLEN 1340 BODWELL RD. MANCHESTER NH 03109

NAME AND ADDRESS OF ISSUER, AGENT OR PRODUCER