

Office Use Only: Date Stamp



Blue Cross MedicareRx Plus (PDP)

Medicare Prescription Drug Plan Individual Short Enrollment Request Form for 2012

Please read the following:

- Use this form only if you are changing Blue Cross MedicareRx Plus (PDP) plans – not to enroll the first time.
- Be sure to complete all appropriate sections of this form and sign where indicated.
- Mail the completed form, *including this cover page*, to the address below:

Enrollment Processing Center
P.O. Box 9282
Oxnard, CA 93031-9282

Or fax the completed form to: 1-877-587-6470

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

C0003_07_148 05/2007

A Medicare-approved Part D sponsor.

Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein. Anthem is the state-licensed, risk-bearing entity offering these plans. Anthem has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs available in this region.

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Individual Short Enrollment Request Form for 2012

Section 1: Please Provide the Following Information (Please print clearly.):			
Name of Plan You Are Enrolling In:			
Last Name	First Name	MI	Birth Date (mm/dd/yyyy)
Membership Number		Email Address (Optional)	
Phone No. ()	Alternate Phone No. ()		County
Permanent Residence: Street Address (cannot use P.O. Box)		City	State ZIP Code
Mailing/Billing Address (only if different from your permanent address)		City	State ZIP Code
Section 1A: Please fill out the following:			
I am currently a member of the _____ Anthem Blue Cross Life and Health Insurance Company plan with a monthly premium of \$_____.			
I would like to change to the _____ Anthem Blue Cross Life and Health Insurance Company plan. I understand that this plan has different prescription drug benefits and a monthly premium of \$_____.			
Section 1B: Certain materials for your plan are available, upon request, in large print and might be available in another language.			
Check here if you would prefer us to send you information in a language other than English or in large print. <input type="checkbox"/> Large print <input type="checkbox"/> Spanish			
Please contact Blue Cross MedicareRx Plus (PDP) at 1-800-928-6201 if you need information in another format or language than what is listed above. TTY users should call 1-877-247-1657 . Our hours of operation are 8 a.m. to 8 p.m., 7 days a week.			
Section 2: Your Plan Premium — Please complete this section only if you are changing your current payment method or choosing a payment option for the first time.			
<p>You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or Electronic Funds Transfer (automatic bank account deduction). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DON'T pay Blue Cross MedicareRx Plus (PDP) the Part D-IRMAA extra amount.</p> <p>Note: People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drugs costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.</p>			

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(Section 2 continued on next page)

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2 of 4 **Please print:** Member Name _____ & Member ID # _____

Section 2 (continued)

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover.

If you don't select a premium payment option below, you will get a bill each month.

Please select a premium payment option:

1. Regular bill: Send me a monthly bill.

2. Automatic deduction from your bank account: I authorize the bank named below to allow monthly deduction of my premium amount from the account indicated below. (*Depending on when you apply, more than one month's premium amount might be deducted for your first payment.*) Please complete A and B below:

A. Bank Account type: Checking: Enclose a VOIDED check.

B. Bank Account Information (*Be sure to enclose a VOIDED check.*)

Account Number

Account Holder's Name

Bank's Name

Bank Routing Number

(The bank routing number is the first 9 digits printed on the lower corner of your check.)

3. Automatic deduction from your monthly Social Security or Railroad Retirement Board benefit check (*The Social Security or Railroad Retirement Board deduction may take two or more months to begin after Social Security or the Railroad Retirement Board approves the deduction. In most cases, if Social Security or the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security or Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. This means your first Social Security or Railroad Retirement Board deduction could be for three times your monthly premium. If Social Security or the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.*)

Section 3: Please Read and Sign at the End of This Section.

Blue Cross MedicareRx Plus (PDP) is a Medicare prescription drug plan and has a contract with the federal government. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Cross MedicareRx Plus (PDP), he/she may be compensated based on my enrollment in Blue Cross MedicareRx Plus (PDP).

Release of Information: By joining this prescription drug plan, I acknowledge that the prescription drug plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that Blue Cross MedicareRx Plus (PDP) will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that Medicare beneficiaries aren't covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Cross MedicareRx Plus (PDP) coverage begins, I must get all of my prescription drug services from Blue Cross MedicareRx Plus (PDP). Prescription drugs authorized by Blue Cross MedicareRx Plus (PDP) and contained in my Blue Cross MedicareRx Plus (PDP) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, neither Medicare nor Blue Cross MedicareRx Plus (PDP) will pay for the services.

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3 of 4 **Please print:** Member Name _____ & Member ID # _____

Section 3: (continued)

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Blue Cross MedicareRx Plus (PDP) or by Medicare.

Signature:*

Today's Date:

**If you are the authorized representative, you must sign above and provide the following information:*

Name	Phone No.	Relationship to Enrollee	
Street Address	City	State	ZIP Code

For Medicare Prescription Drug Plan Use Only:

Internal Agents or External Agents/Brokers, please complete: Coverage Effective Date: ____/____/____
 AEP SEP (type): _____

Direct Sales Reps Only: Complete if you assisted in enrollment.

Print Name: _____ Tax ID (10 digits) or Agent Code (variable): | | | | | | | | | | | | | | | |

Company Received Date Stamp:

Current Agents/Brokers Only: Complete all fields

Please complete all lines below.

Date received from member: _____
I helped the member fill out this form: Yes No
Please check the ID No. to use for commission payment:

Agent/Broker's Tax ID No.:
| | | | | | | | | | | |

Code No.: _____

Agency Tax ID No.:
| | | | | | | | | | | |

Code No.: _____

Agent/Broker Signature: _____

Agent/Broker's Printed Name: _____

Agency Name: _____

Address: _____

Street Address

City State ZIP Code

Phone No.: (____) _____

Fax No.: (____) _____

Email Address: _____