MEDICARE ENROLLMENT APPLICATION

REFERENCE GUIDE

Anthem Blue Cross and Blue Shield
Individual Enrollment Request Form - 2020

Be sure to complete the entire enrollment form. Fax the completed form to **1-800-833-8554** or **mail** the completed form to **P.O. Box 659403, San Antonio TX, 78265-9714**. You can also enroll online at **https://shop.anthem.com/medicare**. **Note:** Your agent/broker may provide different instructions.
Please contact Anthem Blue Cross and Blue Shield if you need information in another language or format (Large Print or Braille).

Please check which plan you want to enroll in.
To add an Optional Supplemental Benefits (OSB) Package, check only one box from the options directly below the medical plan you selected.

☑ **Anthem MediBlue Extra (HMO)**
$20.60 per month

- ☐ **Preventive Dental Package**
  $14.00 per month**
- ☐ **Dental and Vision Package**
  $25.00 per month**
- ☐ **Enhanced Dental and Vision Package**
  $42.00 per month**

** The premium is in addition to your monthly plan premium.

Name, DOB, and Gender must match what SSA has listed.

Last name	First name	MI
Snow	Hodor	

Birthdate (MM/DD/YYYY)	Gender	Home phone number	Alternate phone number
01/19/1949	☐ M ☐ F	555-555-5555	

Permanent residence street address (P.O. Box is not allowed.)
700 Broadway *No punctuations*

City	State	ZIP code	County
Cincinnati	OH	41073	Hamilton

Mailing address (only if different from your permanent residence address)

City	ZIP code

Be sure the plan is offered in the members residential county

Applicant Complete: Name Hodor Snow and Medicare Number 0ZZ0ZZ0ZZ00

500699MUSENMUB_0031
H3655_041-000_OH

enrollment form

Important Page

The more information given on the application the better we can serve our members.

Listing the Name, DOB and Gender to match the Social Security Administration, helps with not having a fallout in the application process.

A

Having punctuations in the address, may cause part of the address to drop off in Medisys causing the member to not get important information about their plan.

B

If the application is not for a plan in the member's county of residence, it could be denied.

C

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this
  Medicare c

-OR-

- Attach a co
  letter from S
  Retirement Board.

D

Must Match Medicare Card

Name (as it appears on your Medicare card): Hodor Snow

Medicare Number: 0ZZ0ZZ0ZZ00

Is Entitled To: Effective Date:

HOSPITAL (Part A) 01/01/2020

MEDICAL (Part B) 01/01/2020

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying your plan premium

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe, and the optional supplemental benefit plan premium, if you enrolled in that plan) by mail or electronic funds transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), 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 benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). DO NOT pay Anthem Blue Cross and Blue Shield the Part D-IRMAA.

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 drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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 also can apply for "Extra Help" online at www.socialsecurity.gov/prescriptionhelp.

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 that Medicare doesn't cover.

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

Please select a premium payment option:

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your **first** payment.) Please complete steps 1 and 2 below:

enrollment form

Applicant Complete: Name Hodor Snow and Medicare Number 0ZZ0ZZ0ZZ00

D

Member Benefit ID must match CMS or the application will error out.

The MBI will contain letters and numbers. Here's an example: 1EG4-TE5-MK73

- The MBI's 2nd, 5th, 8th, and 9th characters will always be a letter.
- Characters 1, 4, 7, 10, and 11 will always be a number.
- The 3rd and 6th characters will be a letter or a number.
- The dashes aren't used as part of the MBI. They won't be entered into computer systems or used in file formats.

MBI Format Pos.

Pos.	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

Where will the MBI's characters go?
C – Numeric 1 thru 9 **N** – Numeric 0 thru 9 **AN** – Either A or N **A** – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

Position 1 – numeric values 1 thru 9
Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 4 – numeric values 0 thru 9
Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 7 – numeric values 0 thru 9
Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 10 – numeric values 0 thru 9
Position 11 – numeric values 0 thru 9

How will the MBI fit on forms?
MBIs will fit on forms the same way HICNs do. You don't need spaces for dashes.

1) Account Type ☐ **Checking:** Must enclose **VOIDED** check or letter from financial institution with account number. ☐ **Savings:** Must enclose letter from financial institution with account information.

E

2) Please complete the following information for your account

Account holder name _____ Bank name _____

Bank routing number* _____ Account number _____

(*This is the first 9 digits printed on the lower left corner of your check.)

I authorize the bank above to deduct my monthly premiums.

Automatic deduction from your monthly ☑ Social Security or ☐ Railroad Retirement Board (RRB) benefit check.

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

F

Please read and answer these important questions:

1. **Do you have end-stage renal disease (ESRD)?** ☐ Yes ☑ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. **Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.**

Will you continue to have other prescription drug coverage? ☐ Yes ☑ No ☐ N/A

If "yes," please list your other coverage and your identification (ID) # for this coverage

Name of other coverage _____

ID # for this coverage _____ Group # for this coverage _____

3. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☑ No

If "yes," please provide the following information:

Name of institution _____

Address _____

City _____ State _____ ZIP code _____ Phone number _____

G

4. **Are you enrolled in your State Medicaid program?** ☑ Yes ☐ No

If "yes," please provide your Medicaid number _____

5. **Do you or your spouse work?** ☐ Yes ☑ No

Applicant Complete: Name Hodor Snow and Medicare Number 0ZZ0ZZ0ZZ00

When the Billing portion is NOT completed, the record will default to DIRECT PAY

E

A call will need to be made to the member if the ESRD question is not answered or differs from CMS.

F

The correct Medicaid number is needed in order to not slow down the process (if needed for Dual plans)

G

H

Please ch[illegible] name of a primary care physician (PCP). If you do not choose a PCP, we will select a high quality listed provider for you.

PCP ID # (as shown in the printed or online Provider Directory) 0279546

PCP name Sheldon (First Name) Cooper (Last Name)

Primary Medical Group (PMG) name

PCP address 8139497 Main St

City Cincinnati State OH ZIP code 45203

Are you now seeing or have you recently seen this doctor? ☑ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish

Assistance for the visually impaired:

☐ Voice-Enabled (Audio) PDF ☐ Large Print

Please contact Anthem Blue Cross and Blue Shield at **1-866-803-5169** if you need information in an accessible format or language other than what is listed above. TTY users should call **711**.

STOP

Please read this important information.

If you currently have health coverage from an employer or union, joining Anthem Blue Cross and Blue Shield could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Anthem Blue Cross and Blue Shield. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions — i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, yo[illegible]e disenrolled.

I

NOTE: You m[illegible]t at least one of the options below.

☑ I am enrolling during the Annual Open Enrollment Period from October 15 to Decembe[illegible]7 (AEP)

☐ I am new to Medicare. (IEP/ICEP)

☐ I am turning 65 and not new to Medicare. (IEP2)

Applicant Complete: Name [illegible] and Medicare Number 022022022200

enrollment form

Providing the correct/complete information about the PCP ensures the member gets the one they want and avoids auto assignment of a different PCP.

H

I

Election Periods

There are six types of election periods during which individuals may make enrollment requests. They are:

- The Annual Election Period (AEP); **10/15 – 12/07 eff 01/01**
- The Initial Coverage Election Period (ICEP); **3 months prior to Part B entitlement**
- Initial Enrollment Period for Part D (IEP for Part D) **3 m**onth **prior, the month of and 3 month after Medicare entitlement**
- The Open Enrollment Period for Institutionalized Individuals (OEPI)
- All Special Election Periods (SEP);
- The Medicare Advantage *Open E*nrollment Period (*MA OEP*)

See https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf for further information

- ☐ I recently moved outside of the service area for my curr or I recently moved and this plan is a new option for me. I moved on (insert date) _____.(SEP)
- ☐ I have both Medicare and Medicaid (or my state helps pa y Medicare premiums) or I get "Extra Help" paying for my Medicare prescription drug coverage, but I haven't had a change. (SEP)
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.(SEP)
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. (SEP)
- ☐ I recently had a change in my Medicaid/"Extra Help" paying for my Medicare prescription drug coverage (newly got Medicaid/"Extra Help", had a change in the level of Medicaid/"Extra Help", or lost Medicaid/"Extra Help") on (insert date) _____. (SEP)
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.(SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____.(SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.(SEP)
- ☐ I am leaving employer or union coverage on (insert date) _____.(SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.(SEP)
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.(SEP)
- ☐ I was recently released from incarceration. I was released on (insert date) _____.(SEP)
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.(SEP)
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)
- ☐ Other* *Not to be used if election period is listed above*

*If none of these statements apply to you or you're not sure, please contact Anthem Blue Cross and Blue Shield at **1-866-803-5169** (TTY users should call **711**) to see if you are eligible to enroll.

Essential Extras

Complete the information below. See the Essential Extras section of the *Summary of Benefits* for more information about each.

Please CHOOSE ONE benefit you and your doctor believe is most appropriate for you. Not ready to choose yet? No problem. After you enroll, you can call the Customer Service phone number on your member ID card to make your selection.

enrolment form

Applicant Complete: Name Hodor Snow and Medicare Number 0ZZ0ZZ0ZZ00

J

Complete the (Insert date) line as needed

Special Election Periods

Special election periods constitute periods outside of the usual IEP, AEP or *MA OEP* when an individual may elect a plan or change his or her current plan election.

See https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf for further information

K

- [x] Alternative Medicine
- [ ] Healthy Food Deliveries
- [ ] Healthy Nutrition
- [ ] Pest Control
- [ ] Transportation
- [ ] Assistive Devices
- [ ] Health and Fitness Tracker
- [ ] Personal Home Helper
- [ ] Service Dog Support
- [ ] Day Center Visits*

*Reimbursement will be contingent upon selected center being licensed by governing state and meeting any and all state requirements.

- [x] I acknowledge and understand that if my plan offers Essential Extras, I am entitled to ONE of those benefits for 2020, and I confirm my physician agrees my selection is appropriate for my care. My plan may contact my provider (listed below) if they need more information. I also understand unused benefits do not roll over to the next calendar year.

Provider Name _____ Provider Phone _____

Email Preferences

Email is the fastest, easiest way to get important information about your plan – and some fun extras, too! Please provide your email address below to sign up for our email program.

Member's email @ _____

By giving my email address, I agree to receive emails about my benefits, health programs and other plan services.
This includes getting digital versions of important, CMS-required plan documents such as the new member Welcome Kit, Annual Notice of Changes, and claim-specific Explanation of Benefits (EOBs).

I understand I can change my email preferences any time by logging into my member profile at **www.anthem.com** or calling customer service.

- [x] I prefer to get my Welcome Kit, Annual Notice of Changes, and EOB in the mail instead.

Please read and sign in the "Applicant signature" box below

By completing this enrollment application, I agree to the following:

Anthem MediBlue Extra (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, October 15 – December 7 of every year), or under certain special circumstances.

Anthem MediBlue Extra (HMO) serves a specific service area. If I move out of the area that Anthem Blue Cross and Blue Shield serves, I need to notify the plan so I can disenroll and find a new plan in my new

Applicant Complete: Name Hodor Snow and Medicare Number 0ZZ0ZZ0ZZ00

Only certain plans offer Essential Extras so pl*ease confirm the selected plan has these supplemental benefits*

K

Please read and sign in the "Applicant signature" box below

area. Once I am a member of Anthem MediBlue Extra (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Anthem Blue Cross and Blue Shield when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare usually 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 Anthem Blue Cross and Blue Shield coverage begins, I must get all of my health care from Anthem Blue Cross and Blue Shield participating providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem Blue Cross and Blue Shield and other services contained in my Anthem MediBlue Extra (HMO) *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Anthem Blue Cross and Blue Shield WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Anthem Blue Cross and Blue Shield, he/she may be paid based on my enrollment in Anthem MediBlue Extra (HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that Anthem Blue Cross and Blue Shield will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Blue Cross and Blue Shield 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 my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) 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 from Medicare.

Signature Required to process your application.

Applicant signature X *Hodar Snow*	Today's date *01/15/2020*
Desired plan effective date*: *02/01/2020*	

*Subject to [illegible] election period guidelines

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name (First Name)	(Last Name)	
Address		
City	State	ZIP code
Phone Number	Relationship to Enrollee	
☐ I have submitted Authorized Representative documentation with this application.		

Applicant Complete: Name _____ and Medicare Number _____

Signature is a must!!!

L

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name		
First Name	Last Name	
Address		
City	State	ZIP code
Phone Number	Relationship to Enrollee	
☐ I have submitted Authorized Representative documentation with this application.		

Applicant Complete: Name Hector Snow and Medicare Number 0ZZ0ZZ0ZZ00

To be completed only if someone other than the member completes the application. (Broker/Agent excluded)

M

N

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.

Coverage effective date 01/01/2020 PLAN ID #: HB432-035-000

☐ IEP/ICEP ☑ AEP ☐ OEP ☐ SEP (type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☑ Yes ☐ No

Was this an individual face-to-face appointment? ☐ No ☑ Yes (if yes, how was a scope of appointment (SOA) collected)? ☐ Paper ☐ Recorded call (voice recording ID) _____

Print name _____ | _____
First Name Last Name

Writing Agent TIN (10 digits)/Agent Code _ _ _ _ _ _ _ _ _ _

Agency TIN (10 digits) or Agency Code _ _ _ _ _ _ _ _ _ _

Agency Name _____

Phone _____

Email @ _____

Signature Your Name Application received date 10/15/2019

1

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Enclosure – 1557 notice

enrollment form

2

Applicant Complete: Name Hodor Snow and Medicare Number 0ZZ0ZZ0ZZ00

Give Yourself Credit

It also helps when this page is complete, sometimes the answers can be found here.

N

1. The date signed can determine the effective date so ensure it is completed

2. Completing the bottom of each page. This is a good habit as answers can be found if the name/MBI is not legible elsewhere

Do Your Homework

The best way to service your member is to submit complete and accurate information.

OSB APPLICATION

Empire BlueCross BlueShield

Office Use Only: Date Stamp

Empire BlueCross BlueShield Optional Supplemental Benefits Package Enrollment Request Form for 2020

Use this form only if you are an existing Medicare Advantage plan member and want to enroll in an Optional Supplemental Benefit (OSB) Package available to you. Optional Supplemental Benefits can only be added during certain times of the year. During AEP from October 15 - December 7, during OSB Open Enrollment Period from December 8 - March 31 or if you are a new member, you can add OSB within the first 90 days of your initial enrollment.

Fax the completed form to: 1-800-833-8554

Or, mail to: Empire BlueCross BlueShield, P.O. Box 659803, San Antonio, TX 78265-9714

A

Provide the following information: *(Please print clearly)*

Choose the Optional Supplemental Benefits Package you want to enroll in.

Empire MediBlue Extra (HMO)

- ☐ Preventive Dental Package $14.00 per month*
- ☐ Dental and Vision Package $24.00 per month*
- ☑ Enhanced Dental and Vision Package $42.00 per month*

* This premium is in addition to your monthly plan premium.

Last name	First name	MI	Birth date (mm/dd/yyyy)
Snow	Hodor		01/10/1948

Member ID number (as it appears on your Medical ID Card)	Email address (optional)
123445679	

Phone number	Alternate phone number	County
555-555-5555		Kings

Permanent residence street address (P.O. Box is not allowed.)	City	State	ZIP code
700 Broadway	Brookland	NY	11204

Mailing/billing address (only if different from your permanent address)	City	State	ZIP code

(continued on next page)

The OSB application must be for same plan the member is currently enrolled.

A

Please read the premium payment information below
Payment is not required at the time of enrollment. The additional premium for your Empire BlueCross BlueShield Optional Supplemental Benefits Package premium will be processed in the same manner as your Empire BlueCross BlueShield Medicare Advantage plan. If you do not currently pay a monthly plan premium, you will be billed monthly unless you contact us to change your payment method.

Please read and sign at the end of this section
I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in my Medicare Advantage plan in order to be enrolled in the optional plan selected. Additionally, I understand that I must pay the optional plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) 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 from Medicare. **Signature required to process your application.**
Applicant signature Hodor Snow **Today's date** 01/15/2020
Desired plan effective date 02/01/2020

B

Authorized Representative Information Only	
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.	
First name	Last name
Address	
Phone number	Relationship to Enrollee
☐ I have submitted Authorized Representative documentation with this application.	

(continued on next page)

Signature is a must!

C

Applicant: Please do not complete the following sections.

Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND producer.

Coverage effective date 02/01/2020 ☐ AED ☑ OSB

I helped the member fill out this form ☑ Yes ☐ No

Was this an individual face-to-face appointment? ☑ Yes ☐ No If yes, how was a scope of appointment (SOA) collected? ☑ Paper ☐ Recorded call (voice recording ID) _____

Print name Your Name

Writing Agent: TIN (10 digits)/Agent Code _ _ _ _ _ _ _ _ _ _

Agency TIN (10 digits)/Agent Code _ _ _ _ _ _ _ _ _ _

Agency name _____

Phone _____

Email @ _____

Signature Your Name Application received date 01/15/2020

1

Services provided by Empire HealthChoice HMO, Inc. licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

[1557 Disclaimer]

Member Name Hodor Snow & Member ID # 123A45678

2

Give Yourself Credit

It also helps when this page is complete, sometimes the answers can be found here.

C

1. The date signed can determine the effective date so ensure it is completed

2. Completing the bottom of each page. This is a good habit as answers can be found if the name/MBI is not legible elsewhere