MediBlue℠ HMO

Individual Change Request Form – 2009

Please read the following:

- **Be sure to complete all appropriate sections of this form and sign where indicated.**
- **Return the completed form, *including this cover page*, to the address below:**

Anthem Blue Cross and Blue Shield
P.O. Box 36110
Louisville, KY 40233-6110

Or fax the completed form to: 1-877-762-4036

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.
M0013_07_079 05/2007

This plan is an HMO with a Medicare contract.

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Office Use Only: Date Stamp

MediBlue HMO

Anthem

Individual Change Request Form – 2009

Use this form only if you are changing MediBlue HMO plans — not to enroll the first time.

Name of Plan You are Enrolling In: ____

Section 1: Member Data (Please print)

Last Name	First Name	Middle Initial

Permanent residence street address (cannot use P.O. Box)	City	County

State	ZIP Code	Phone No.	Alternate Phone No.	Member Identification No.	Sex	Date of Birth
		( )	( )		☐M ☐F	

Mailing/Billing Address (if different from address above)	City	State	ZIP Code

Section 2: Benefit Plan Selection

For information about the service areas and the premiums, if any, of the Medicare Advantage plans available to you, please refer to your Summary of Benefits.

I am currently a member of the ________________ plan in MediBlue HMO with a monthly premium of $__________.

I would like to change to the ________________ plan in MediBlue HMO. I understand that this plan has different health benefits and a monthly premium of $__________.

Section 3: Paying 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.

If you are enrolling in a plan without any premium: If the plan includes Medicare Part D prescription drug coverage, and we determine that you owe a late enrollment penalty for the Part D portion of your plan, we need to know how you would prefer to pay it. Please choose one of the payment options in the checklist below.

If you are enrolling in a plan with a monthly premium, how would you like to pay future plan premiums? You can pay your monthly plan premium by mail. You might also be able to pay your premium by automatic deduction from your Social Security Check each month *(see below)*.

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or some portion of your plan premium. However, because you might be responsible for paying part of your premium, you still must choose a premium payment option. We must receive payment for the amount that Medicare does not cover.

Please choose one of the payment options below: *(If no option is chosen, you will receive a monthly bill for the amount due.)*

☐ Monthly Bill: Send me a bill each month.

☐ Automatic Social Security Deduction: Deduct the amount from my Social Security benefit check each month. *(If you choose this option, your monthly Social Security check should be at least 3 times your monthly premium. The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date to the date withholding begins.)*

Section 4: Please indicate if you prefer information in another language or format.

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

- ☐ In Spanish. (To see if materials in Spanish are available for your plan, please call Customer Service at the phone number shown on your Member Identification Card.)
- ☐ In large print

If you need more information about materials in a format other than shown above, call Customer Service at the phone number shown on your Member Identification Card.

Section 5: Please choose a Primary Care Physician (PCP) from the plan's Provider Directory. Write your choice below.

Provider name ______________________

Provider address ______________________

____

____

PCP ID # *(see directory.)* ______________________

New physician for you? ☐ YES ☐ NO

Section 6: ***Important:*** **Read this information before signing in Section 7 below.**

MediBlue HMO is a plan that has a contract with the Federal Government.

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

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the plan will release my information, including my prescription drug data, to Medicare, who may release it for research and other purposes that 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 are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

Note: *Failure to agree with all of the terms and conditions in the Release of Information statement above will result in a denial of your enrollment due to an inability to provide benefits and process claims.*

I understand that, beginning on the date MediBlue HMO coverage begins, I must get all my health care from MediBlue HMO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by MediBlue HMO and other services contained in my MediBlue HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor MediBlue HMO will pay for the services.**

Section 7: Signature

I understand that my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) means that I have read and understand the contents of this form. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this form and 2) documentation of this authority is available upon request by Anthem or by Medicare.

Your signature*	Today's Date

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

Name	Phone no.	Relationship to enrollee	
Street Address	City	State	ZIP code

Office staff and Agents/Brokers: Please complete information on back page.

 Member — please print: Name ______________________ & Member D# ______________________

Member: Please do not complete the following sections. ***For Office Use and Current Agent/Broker Use Only.***

Office Use: Company Received Date Stamp:

Name of Staff Member (if assisted in enrollment):

Required: **Check election period and include effective date.**

☐ ICEP (1) __________ ☐ AEP (3) __________

☐ SEP (2) __________ ☐ OEP (4) __________

SEP Reason __________________

☐ *Not Eligible* __________________

Plan ID No.	**Effective Date**

Current Agent/Broker: complete all fields

Date received from member: __________________

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

Please check the Code No. to use for commission payment:

☒ Agent/ Broker's Code No.: 00522

☐ Agency Code No.: __________________

Agent/Broker

Signature __________________

Date __________________

Agent/Broker's Printed Name: James Gulalo

Agency Name: Preferred Insurance Svs

Address 87 South Main St, Ste 15

Street address

Newtown, CT 06470

City *State* *ZIP code*

Phone No.: (203) 270-9500

Fax No.: (203) 426-9655

E-Mail Address: jimins49@aol.com

 Member — please print: Name __________________ & Member D# __________________