




Anthem SmartValue (PFFS) Employer Group Health Plan Enrollment Election Form

Please contact Anthem Blue Cross and Blue Shield if you need information in another language or format (Braille).

To Enroll in Anthem SmartValue (PFFS), Please Provide the following Information:																								
Employer or Union Name:	Group #:																							
Please write in the name of the plan in which you want to be enrolled:		Requested effective date of coverage (__/__/____) (MM/DD/YYYY)																						
LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.																					
Birth Date: (__/__/____) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: () Alternate Phone Number: ()																						
Permanent Residence Street Address (P.O. Box is not allowed):																								
City:	State:	ZIP Code:																						
Mailing Address (only if different from your Permanent Residence Address):																								
City:	State:	ZIP Code:																						
E-mail Address:																								
Please Provide Your Medicare Insurance Information																								
<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card <p>- OR -</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>		<div style="border: 1px solid black; padding: 10px;"> <table style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #cccccc;"> <td style="text-align: center; padding: 5px;">MEDICARE</td> <td style="text-align: center; padding: 5px;"></td> <td style="text-align: center; padding: 5px;">HEALTH INSURANCE</td> </tr> <tr style="background-color: #cccccc;"> <td colspan="3" style="text-align: center; padding: 5px;">SAMPLE ONLY</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Name: _____</td> </tr> <tr> <td style="padding: 5px;">Medicare Claim Number</td> <td style="padding: 5px;">Sex: <input type="checkbox"/> M <input type="checkbox"/> F</td> <td style="padding: 5px;">_____ - _____ - _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Is Entitled To _____ Effective Date _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">HOSPITAL (Part A) _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">MEDICAL (Part B) _____</td> </tr> </table> </div>		MEDICARE		HEALTH INSURANCE	SAMPLE ONLY			Name: _____			Medicare Claim Number	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	_____ - _____ - _____	Is Entitled To _____ Effective Date _____			HOSPITAL (Part A) _____			MEDICAL (Part B) _____		
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Please read and answer these important questions

1. Are you the retiree? Yes No

If yes, retirement date (month/date/year): _____

If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? Yes No

If yes, name of spouse: _____

Name of dependents: _____

3. Do you or your spouse work? Yes No

4. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered “yes” to this question and you do not need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

5. Some individuals may have other drug coverage, including other private insurance, Worker’s Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have [other] prescription drug coverage in addition to Anthem SmartValue (PFFS)? Yes No

If “yes”, please list your [other] coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for Coverage: _____

6. 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 & Phone Number of Institution (number and street): _____

Please Choose a Primary Care Physician (PCP), clinic or health center:

If you need information in another format, such as large type, or in another format (like Braille, audio tape, or large print), please contact our Customer Service department at the phone number indicated in the enrollment brochure.

Please Read and Sign Below

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

Anthem SmartValue (PFFS) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can only be in 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 plan. It is my responsibility to inform Anthem SmartValue (PFFS) of any health coverage that I have or may get in the future. [I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31), or under certain special circumstances.

Anthem SmartValue (PFFS) serves a specific service area. If I move out of the area that Anthem SmartValue (PFFS) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Anthem SmartValue (PFFS), 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 SmartValue (PFFS) when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage 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.

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information:

By joining this Medicare health plan, I acknowledge that the Medicare 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 Anthem SmartValue (PFFS) 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 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 Anthem SmartValue (PFFS) or by Medicare.

Signature: _____	Today's Date: _____
If you are the authorized representative, you must sign above and provide the following information:	
Name: _____	
Address: _____	
City: _____ State: _____ Zip: _____	
Phone Number: (____) ____ - _____	
Relationship to Enrollee _____	

Office Use Only:

Name of staff member/agent/broker *(if assisted in enrollment)*: _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Please return this application to:



Anthem Blue Cross and Blue Shield
 P.O. Box 110
 Fond du Lac, Wisconsin 54936

Please refer to the Anthem Blue Cross and Blue Shield Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Anthem Insurance Companies, Inc (AICI) is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. AICI is the risk bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. AICI has retained the services of its related companies and the authorized agents/ brokers/producers to provide administrative services and/or to make the PFFS plan (s) available in this region. Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.): Anthem Health Plans of Virginia, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin (“BCBSWi”) underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (“CompCare”) underwrites or administers the HMO policies; and CompCare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.