

Anthem Medicare Preferred (PPO) 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 Medicare Preferred (PPO), 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) <small>The effective date of enrollment will be the first of the month following the signature date, unless a future date is requested.</small>
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

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

- Please fill in these blanks so they match your Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

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

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) _____		

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. Do you have other medical insurance? Yes No

If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____

What are the effective dates of coverage? _____

6. 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 Medicare Preferred (PPO)? 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 _____

7. 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 and 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 Medicare Preferred (PPO) 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 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 Medicare Preferred (PPO) 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 October 15 - December 7), or under certain special circumstances.

Anthem Medicare Preferred (PPO) serves a specific service area. If I move out of the area that Anthem Medicare Preferred (PPO) 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 Medicare Preferred (PPO), 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 Medicare Preferred (PPO) when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that other people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that the effective date of enrollment will be the first of the month following the signature date, unless a future date is requested. Beginning on the date Anthem Medicare Preferred (PPO) coverage begins, I must get all of my health care from Anthem Medicare Preferred (PPO), with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem Medicare Preferred (PPO) and other services contained in my Anthem Medicare Preferred (PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ANTHEM MEDICARE PREFERRED (PPO) 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 Medicare Preferred (PPO), he/she may be paid based on my enrollment in Anthem Medicare Preferred (PPO).

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

Release of information: By joining this Medicare health plan, I acknowledge that Anthem Medicare Preferred (PPO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Medicare Preferred (PPO) 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 by Anthem Medicare Preferred (PPO) or by Medicare.

Signature	Today's date
<p>If you are the authorized representative, you must sign above and provide the following information:</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ ZIP code _____</p> <p>Phone number (____) ____ - _____</p> <p>Relationship to enrollee _____</p>	

Office use only

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

Plan ID # _____

Effective date of coverage _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not eligible _____

Please return this application to:



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 este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

A PPO plan with a Medicare contract. Rocky Mountain Hospital and Medical Service, Inc. (d/b/a Anthem Blue Cross and Blue Shield) is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS), and is the risk-bearing entity licensed under applicable state law, to offer the Preferred Provider Organization plan(s) (PPO) noted above or herein. Rocky Mountain has retained the services of the following related Anthem Blue Cross and Blue Shield companies and their authorized agents/brokers/producers to provide administrative services and/or to make the PPO plan(s) available in these regions: In Connecticut: Anthem Health Plans, 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 RIT and certain affiliates administer non-HMO benefits underwritten by HALIC. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin (“BCBSWi”), which underwrites or administers the PPO and indemnity policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.