Insurance and Benefits Trust/Committee
Peace Officers Research Association
of California

RE: Senior Prescription Drug Plan provided by your PORAC Anthem Blue Cross Health Plan

We have identified that you are eligible for the Medicare Supplement Health Plan. In order to process your enrollment, the Medicare Supplement enrollee is **REQUIRED** to complete the enclosed form, **"Anthem Blue Cross MediCareRx (PDP) (Part D" employer Group Health Plan Enrollment Election Form. It is IMPERATIVE that you complete and return the enclosed form. Please also confirm that you are a current PORAC Member.**

Please complete the following form in its entirety. **Each Supplement to Medicare participant must complete and sign a form.**

Completion of the form means entering:

Employer or Union Name: **PORAC** Group#: **From current Anthem Blue Cross Card**

Name of Plan: **PORAC Anthem Blue Cross Health Plan**

Requested Effective Date: **First Day of your Birth date Month or Use the Medicare Date**

Your full name Birth Date Sex Applicable telephone numbers

Your Street Address, City and Zip E-mail address (if available)

On the Sample Medicare Card please fill in the blanks with the data on your Medicare card.

Sign form **(must be signed or not valid)** Date form **(must be dated or not valid)**

If you have any questions regarding this form, please call Hakita Grewal, I&BT Insurance Services Representative IMMEDIATELY at PORAC Headquarters 800-655-6397 or e-mail your question to hgrewal@ibtofporac.org. Please fax the completed form to 916-999-8892.

Thank you in advance, the IBT of PORAC appreciates your prompt attention to this matter.

Hakita Grewal
Insurance Services Representative
Insurance & Benefit of PORAC Trust

Anthem BlueCross

Anthem Blue Cross Group Sponsored Health Plan Enrollment Election Form

To enroll in Blue Cross MedicareRx (PDP), please provide the following information:

Group Sponsor Name*	Group #
Please write in the name of the plan in which you want to be enrolled.	Requested effective date of coverage (__ __/__ __/__ __ __ __) *(M M / D D / Y Y Y Y)* Generally, the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birthdate (__ __/__ __/__ __ __ __) *(M M / D D / Y Y Y Y)*	Sex ☐ M ☐ 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

Email address
Your email address will be used for communications only from Anthem Blue Cross. We will not share your email 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 or Part B (or both) to join a Medicare prescription drug plan (PDP).

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex: _____

__ __ __ – __ __ – __ __ __ __

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 _____ Retiree Medicare ID #_____

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, Workers' Compensation, VA benefits or from state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Blue Cross MedicareRx (PDP) and Senior Rx Plus? ☐ 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 _____

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 (number and street) and phone number of institution _____

_____

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Center number listed in this document for additional information.

Please read this important information:

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Blue Cross MedicareRx (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Blue Cross MedicareRx (PDP) could affect your employer or union health benefits. You could lose your employer-sponsored or union-sponsored health coverage if you join Blue Cross MedicareRx (PDP). Please 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below:

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

Blue Cross MedicareRx (PDP) is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Cross MedicareRx (PDP) of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in Blue Cross MedicareRx (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Election Period (October 15 – December 7), unless I qualify for certain special circumstances.

Blue Cross MedicareRx (PDP) serves a specific service area. If I move out of the area that Blue Cross MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Blue Cross MedicareRx (PDP) network pharmacies. Once I am a member of Blue Cross MedicareRx (PDP), 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 when I get it to know which rules I must follow in order to get coverage.

I understand that generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed. If I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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

Release of information:

By joining this Medicare prescription drug plan, I acknowledge that Anthem Blue Cross 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 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 state law 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	**Today's Date**

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

Name _____

Address _____

City _____ **State** _____ **ZIP code** _____

Phone number (____) ____ – _____

Relationship to enrollee _____

Anthem BlueCross

HIPAA Authorization

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, select YES. A HIPAA (Health Insurance Portability and Accountability Act) Authorization form will be mailed to you. This form is valid for one year from the signature date.* If you select NO, a future request for this form can be made by contacting Customer Service at the telephone number on the back of your membership card.

☐ Yes ☐ No

Applicant Signature _____ Date _____

* If you wish to continue having the authorized representative on your account, a new form is required annually.

Please return this application to:

PORAC
Insurance and Benefits
4010 Truxel Rd
Sacramento, CA 95834

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

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the First Impressions number listed in this document to request interpreter services.

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal. Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare & 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. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.