

Anthem Blue Cross Group-Sponsored Health Plan Enrollment Election Form

To enroll in Blue Cross MedicareRx (PDP) with Senior Rx Plus, 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	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birthdate (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	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	
Email address <i>Your email address will be used for communications only from Anthem Blue Cross. We will not share your email address.</i>			
Please provide your Medicare insurance information			
Please take out your red, white and blue Medicare card to complete this section. · Please fill out this information as it appears on your Medicare card. - OR - · Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan (PDP).		Name (as it appears on your Medicare card):	
		Medicare Number:	
		Is Entitled To:	Effective Date:
		HOSPITAL (Part A)	
		MEDICAL (Part B)	

* Employer or Union Group

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) with Senior Rx Plus 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 Team 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) with Senior Rx Plus, 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) with Senior Rx Plus 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) with Senior Rx Plus. 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) with Senior Rx Plus 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) with Senior Rx Plus 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) with Senior Rx Plus 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) with Senior Rx Plus serves a specific service area. If I move out of the area that Blue Cross MedicareRx (PDP) with Senior Rx Plus 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) with Senior Rx Plus network pharmacies. Once I am a member of Blue Cross MedicareRx (PDP) with Senior Rx Plus, 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 _____	

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 Member Services 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
Attn: 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.

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