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

RE: Medicare Enrollment

Dear Member:

Our records indicate that you are eligible for the PORAC sponsored Medicare Supplement Health Plan. We are providing the below information to assist you through this process.

Within 60 days of your 65th birthday, please complete the steps below. All completed documents must be received prior to the month you turn 65 in order for coverage to be effective by your 65th birthday.

1. Contact Social Security at (800) 772-1213 to enroll in Medicare or enroll online at: https://secure.ssa.gov/iClaim/rib.

2. Once you have enrolled in Medicare, provide CalPERS with your completed Certification of Medicare Status by sending it **via fax** to CalPERS at (800) 959-6545.

3. Once you have received your Medicare ID cards and have sent proof of your Medicare enrollment to CalPERS, complete the enclosed form to enroll in the Anthem Blue Cross Senior Prescription Plan. This plan is already a part of your supplemental health plan coverage and there is no addition cost to enroll. **You must complete this form in order to have prescription coverage.**

4. Please include a copy of your Medicare Part A and B ID card along with your completed prescription enrollment form.

   For complete information on your supplemental Insurance health Plan and Senior RX Plus Prescription coverage, please visit our website at:

https://ibtofporac.org/benefits-offered/health-plans/evidence-of-coverage/

In order to process your enrollment, you **MUST** complete and sign the enclosed **Anthem Blue Cross Senior Prescription (PDP) Enrollment Form.**

2960 Advantage Way, Sacramento, CA 95834 Phone: 800.655.6397 Fax: 916. 999.8892

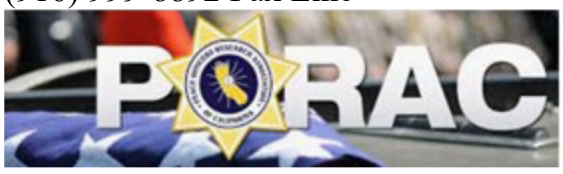
Please use these instructions below to complete the Enrollment Form:

- Employer or Union Name: PORAC
- Anthem Blue Cross Medical Group # – The group number from your Anthem Blue Cross medical ID card
- Name of Plan – PORAC Police & Fire Health Plan
- Requested Effective Date – date your Medicare coverage becomes effective
- Full name
- Date of birth
- Sex
- Phone numbers
- Street Address, City, State and Zip Code
- E-mail address
- Under the Medicare Information section, fill in the blanks with the information from your Medicare card
- Date: Date you are signing the form, **your prescription coverage will not be effective until the 1st of the month following receipt of the form**.

You may return the form to us in the enclosed return envelope or fax the completed form to the Insurance and Benefits Trust of PORAC at (916) 999-8892 or e-mail it to healthplan@ibtofporac.org.

Thank you,

Elisa Kershner
Insurance Services Representative
Insurance & Benefits Trust of PORAC
2960 Advantage Way
Sacramento, CA 95834
(800) 655-6397 Toll Free Line
(916) 999-8892 Fax Line



Anthem

Anthem Blue Cross Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*

Group sponsor name: **Insurance and Benefits Health Plan**	Group #: **CA006GRX**
Plan you will join: ☑ **Blue Cross MedicareRx (PDP) with Senior Rx Plus**	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.

FIRST name: LAST name: Middle initial:

Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other

Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street 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. Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email, phone call or text with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by ☐ email and/or ☐ text? Messaging and data rates may apply.

Please know you can change your preference at any time by visiting www.anthem.com/ca or contacting customer service.

Race*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander
- ☐ I choose not to answer

Ethnicity*

- ☐ Not of Hispanic, Latino/a, or Spanish Origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish Origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Your Medicare information:

Medicare Number: _____

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your Medicare ID Card, your enrollment into the plan may be delayed.

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. 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:_____

_____

3. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-866-646-2436**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

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 a group sponsor, joining Blue Cross MedicareRx (PDP) with Senior Rx Plus could affect your group sponsor health benefits. You could lose your group-sponsored health coverage if you join Blue Cross MedicareRx (PDP) with Senior Rx Plus. Please read the communications your group sponsor 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.

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this prescription drug plan, I acknowledge that the 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 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 election 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

- I understand that when my Blue Cross MedicareRx (PDP) with Senior Rx Plus coverage begins, I must get all of my prescription drug benefits from Anthem Blue Cross. Benefits and services authorized by Anthem Blue Cross and contained in my Blue Cross MedicareRx (PDP) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem Blue Cross will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Please return this enrollment election form to:

Insurance and Benefits Health Plan
Attn: Insurance and Benefits
2960 Advantage Way
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 Welcome Team 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 is an independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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