Insurance and Benefits Trust *of PORAC*

RE: Medicare Enrollment

Dear Member:

Our records indicate that you are eligible for the PORAC sponsored Medicare Supplement Health Plan.

Within 60 days of your 65th birthday, please complete the steps below:

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.**

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: (916) 437-7901 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. If this form is not dated and received by us prior to your 65th birthday, **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 Ekershner@ibtofporac.org.

Thank you,

Elisa Kershner
Customer Service Representative

Insurance & Benefits Trust of
PORAC
2960 Advantage Way
Sacramento, CA 95834
(916) 437-7901 Direct 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 marked optional)

Group sponsor name: PORAC	Group #:
Plan you will join: ☑ Blue Cross MedicareRx (PDP) with Senior Rx Plus / PORAC Police and Fire Health Plan	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.

Your Medicare information:

Medicare Number:

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:

Anthem.

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, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form on the next page, and **sign and return it with this form.** This form is valid for one year from the signature date. • If you don't complete the HIPAA form at this time, a future request for this form can be made by contacting Member Services at the telephone number on the back of your membership card. • If you wish to continue having the authorized representative on your account, a new form is required annually. • If you have a durable health care power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

PORAC
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.

Instructions for completing the *Pre-member/member authorization form*

Anthem

If you have any questions, please call the First Impressions Welcome Team.

Please read the following for help completing page one of the form.

Part A: pre-member/member information

This section applies to the pre-member/member who is asking for the release of their information to another person or company.

1. Print your last name, first name and middle initial.
2. Write your date of birth in this format: MM/DD/YYYY. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state and ZIP code.
4. Write your daytime phone number (including area code).
5. Write your cell/mobile phone number (including area code).
6. Write your identification number (issued when enrolled as a member). You will find this number on your membership card.
7. Write your group number. You will find this number on the enrollment election form. If your enrollment election form does not have a group number, leave this blank.

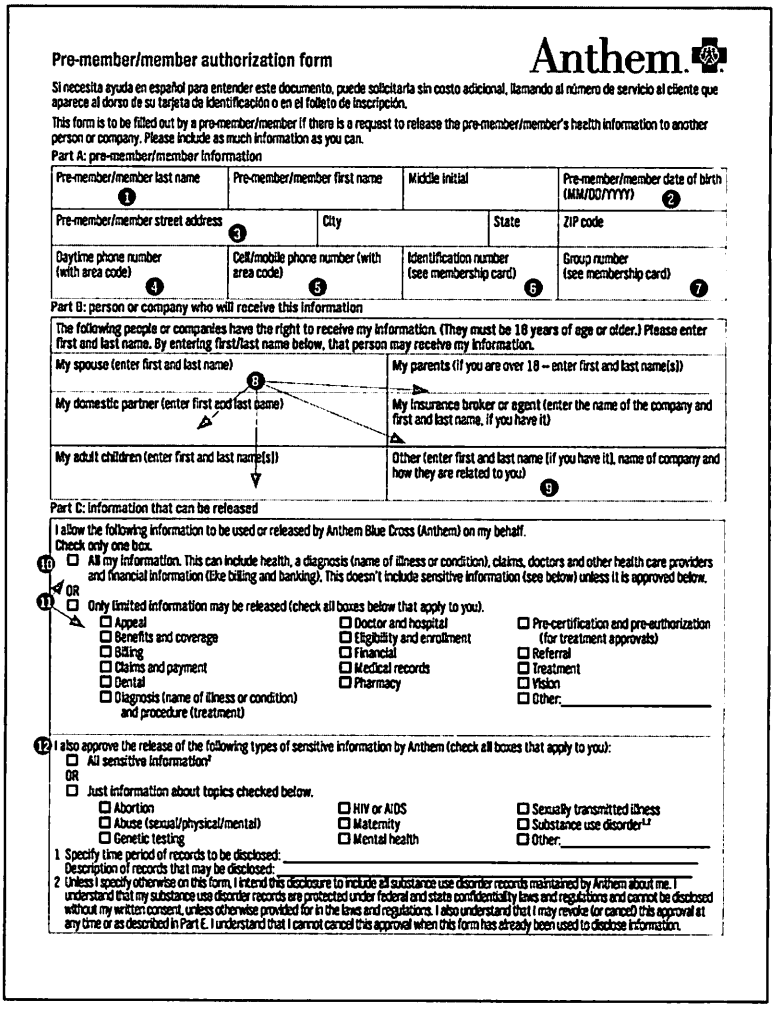
Part B: person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son," as it will not be accepted. You need to be specific.
9. If you check "Other," give the first and last name (if available), the name of the company (if applicable) and how they relate to you.

Part C: information that can be released

This section tells us what information you would like us to release: all or just some.

10. For all of your information, check the first box.
11. For limited information, check the second box and the boxes that apply to you.
12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



Pre-member/member authorization form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a pre-member/member if there is a request to release the pre-member/member's health information to another person or company. Please include as much information as you can.

Part A: pre-member/member information

Pre-member/member last name (1)	Pre-member/member first name	Middle initial	Pre-member/member date of birth (MM/DD/YYYY) (2)
Pre-member/member street address (3)	City	State	ZIP code
Daytime phone number (with area code) (4)	Cell/mobile phone number (with area code) (5)	Identification number (see membership card) (6)	Group number (see membership card) (7)

Part B: person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please enter first and last name. By entering first/last name below, that person may receive my information.

My spouse (enter first and last name) (8)	My parents (if you are over 18 – enter first and last name(s))
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name(s))	Other (enter first and last name (if you have it), name of company and how they are related to you) (9)

Part C: information that can be released

I allow the following information to be used or released by Anthem Blue Cross (Anthem) on my behalf.
Check only one box.

(10) ☐ All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

(11) ☐ Only limited information may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Dental
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pharmacy
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Vision
- ☐ Other: _____

(12) I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

☐ All sensitive information[2]

OR

☐ Just information about topics checked below.

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Substance use disorder[1,2]
- ☐ Other: _____

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please read the following for help completing page two of the form.

Part D: purpose of this approval

This section tells us the reason you've asked for the release of your information.

- ❶ Check the first box to let us know to give out this information as shown on this form.
- ❷ Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: date your approval expires

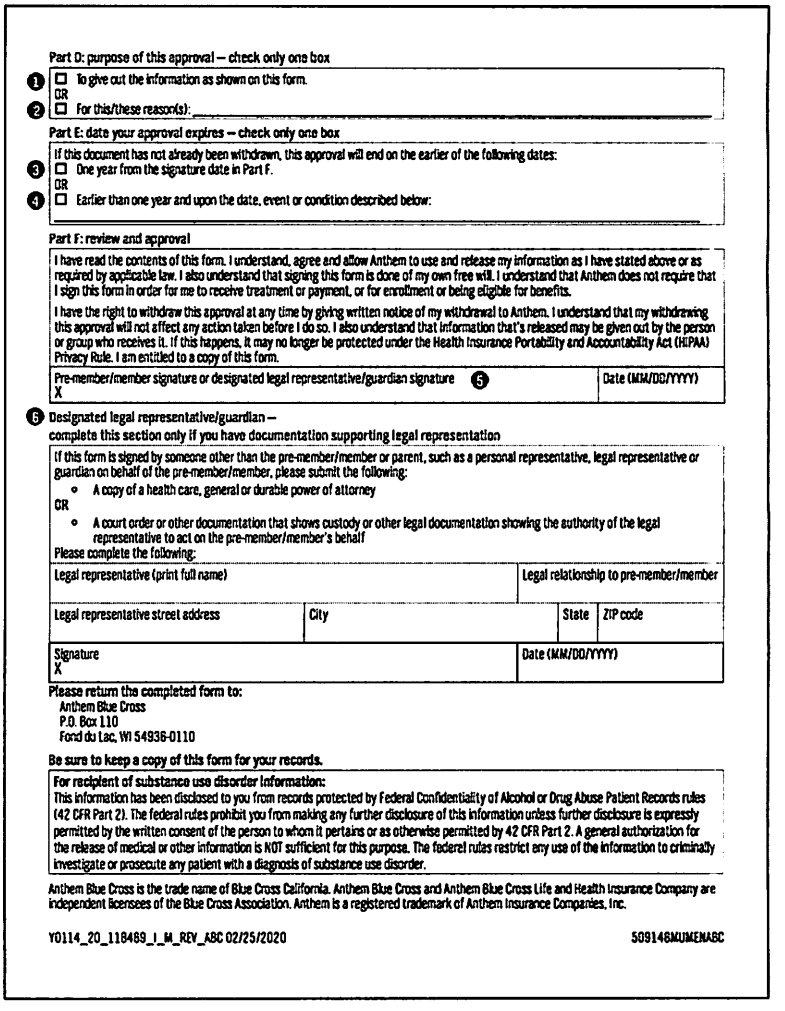
You have two choices of when you would like this approval to end.

- ❸ Check the first box for the approval to end after one year, which is standard.
- ❹ Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

Part F: review and approval

- ❺ **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
- ❻ **If you are signing this form on behalf of another person, or if you have power of attorney for health care or are a legal guardian/conservator, you must do the following:**
  - You must complete the designated legal representative/guardian section.
  - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: purpose of this approval – check only one box

❶ ☐ To give out the information as shown on this form.
OR
❷ ☐ For this/these reason(s): _____

Part E: date your approval expires – check only one box

If this document has not already been withdrawn, this approval will end on the earlier of the following dates:
❸ ☐ One year from the signature date in Part F.
OR
❹ ☐ Earlier than one year and upon the date, event or condition described below: _____

Part F: review and approval

I have read the contents of this form. I understand, agree and allow Anthem to use and release my information as I have stated above or as required by applicable law. I also understand that signing this form is done of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I am entitled to a copy of this form.

Pre-member/member signature or designated legal representative/guardian signature ❺ X	Date (MM/DD/YYYY)

❻ Designated legal representative/guardian –
complete this section only if you have documentation supporting legal representation

If this form is signed by someone other than the pre-member/member or parent, such as a personal representative, legal representative or guardian on behalf of the pre-member/member, please submit the following:
- A copy of a health care, general or durable power of attorney

OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the pre-member/member's behalf

Please complete the following:

Legal representative (print full name)		Legal relationship to pre-member/member	
Legal representative street address	City	State	ZIP code
Signature X		Date (MM/DD/YYYY)	

Please return the completed form to:
Anthem Blue Cross
P.O. Box 110
Fond du Lac, WI 54936-0110

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information:
This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

Anthem Blue Cross is the trade name of Blue Cross California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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Examples of legal documents:

- **Health care, general or durable power of attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal guardianship.** This is when the court appoints someone to care for another person.
- **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for themselves.
- **Executor of estate.** This type of document would be used when the person who is being represented has died.

Pre-member/member authorization form

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a pre-member/member if there is a request to release the pre-member/member's health information to another person or company. Please include as much information as you can.

Part A: pre-member/member information

Pre-member/member last name	Pre-member/member first name	Middle initial	Pre-member/member date of birth (MM/DD/YYYY)
Pre-member/member street address	City	State	ZIP code
Daytime phone number (with area code)	Cell/mobile phone number (with area code)	Identification number (see membership card)	Group number (see membership card)

Part B: person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older.) Please enter first and last name. By entering first/last name below, that person may receive my information.	
My spouse (enter first and last name)	**My parents** (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	**My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	**Other** (enter first and last name [if you have it], name of company and how they are related to you)

Part C: information that can be released

I allow the following information to be used or released by Anthem Blue Cross (Anthem) on my behalf.
Check only one box.

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Dental
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pharmacy
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Vision
- ☐ Other:_____

I also approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

☐ **All sensitive information**[2]

OR

☐ **Just information about topics checked below.**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Substance use disorder[1,2]
- ☐ Other:_____

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Part D: purpose of this approval – check only one box

☐ To give out the information as shown on this form.
OR
☐ For this/these reason(s): _____

Part E: date your approval expires – check only one box

If this document has not already been withdrawn, this approval will end on the earlier of the following dates:
☐ One year from the signature date in Part F.
OR
☐ Earlier than one year and upon the date, event or condition described below:

_____

Part F: review and approval

I have read the contents of this form. I understand, agree and allow Anthem to use and release my information as I have stated above or as required by applicable law. I also understand that signing this form is done of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I am entitled to a copy of this form.

Pre-member/member signature or designated legal representative/guardian signature **X**	Date (MM/DD/YYYY)

Designated legal representative/guardian –
complete this section only if you have documentation supporting legal representation

If this form is signed by someone other than the pre-member/member or parent, such as a personal representative, legal representative or guardian on behalf of the pre-member/member, please submit the following:

- A copy of a health care, general or durable power of attorney

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the pre-member/member's behalf

Please complete the following:

Legal representative (print full name)		Legal relationship to pre-member/member	
Legal representative street address	City	State	ZIP code
Signature **X**		Date (MM/DD/YYYY)	

Please return with enrollment election form.

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information:
This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.