Anthem

Anthem Blue Cross Life and Health Insurance Company Group Sponsored Health Plan Enrollment Election Form

To enroll in Anthem Medicare Preferred (PPO) with Senior Rx Plus, please provide the following information:	
Group Sponsor name* Contra Costa Community College District	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 Life and Health Insurance Company. 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 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 and Part B to join a Medicare Advantage plan. You will need to keep Medicare Parts A and B.	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. Do you have end-stage renal disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

3. 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? _____

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or from state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Anthem Medicare Preferred (PPO) with 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 number for coverage _____

5. 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 and sign below

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

Anthem Medicare Preferred (PPO) with Senior Rx Plus 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) with Senior Rx Plus of any prescription drug coverage that I have or may get in the future. If my plan does not include prescription drug coverage, I understand that if I don't have other 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 Election Period from October 15 – December 7) or under certain special circumstances.

Anthem Medicare Preferred (PPO) with Senior Rx Plus serves a specific service area. If I move out of the area that Anthem Medicare Preferred (PPO) with Senior Rx Plus 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) 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 Life and Health Insurance Company when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that 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 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. Beginning on the date Anthem Blue Cross Life and Health Insurance Company coverage begins, I must get all of my health care from Anthem Blue Cross Life and Health Insurance Company, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem Blue Cross Life and Health Insurance Company and other services contained in my Anthem Medicare Preferred (PPO) 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 LIFE AND HEALTH INSURANCE COMPANY WILL PAY FOR THE SERVICES.

Release of information: By joining this Medicare health plan, I acknowledge that Anthem Blue Cross Life and Health Insurance Company 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 Life and Health Insurance Company 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 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

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 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:

Contra Costa Community College District
Attn: Reed Rawlinson
500 Court Street, 6th Floor
Martinez, CA 94553

Please refer to the Anthem Blue Cross Life and Health Insurance Company *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.