Anthem

Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless marked optional		
Group sponsor name: **Elk Grove Benefits Employee Retirement Trust (EGBERT)**		Group #: **MA: CA069GRS PDP: CA029GRX**
Plans you will join: **Medicare Advantage:** Anthem Medicare Preferred (PPO) **Prescription Drug:** Blue Cross MedicareRx (PDP) with Senior Rx Plus ** Enrollment in the prescription drug plan depends on approval of your Medicare Advantage enrollment by CMS and will be processed once approval is received.*		Requested effective date of coverage: (__ __/__ __/__ __ __ __) (MM/DD/YYYY) 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. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):		
City:	State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed): Street address: City: State: ZIP code:		
(Optional) **Email address:** _____ Your email address will be used for communications only from Anthem. We will not share your email address. The email will be used to contact you with Important Plan Information or additional products and services that might interest you. There are options to change your preferences at any time by visiting **www.anthem.com/ca** or contacting Member Services.		
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 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. Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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. 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: _____

_____

5. 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 **1-833-848-8729**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays., for additional information or questions you may have.

IMPORTANT: Read and sign below:

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

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining these Medicare Advantage and Part D prescription drug plans, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Anthem 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 these plans.
- 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 once my coverage begins, I must receive all medical and prescription drug benefits through Anthem. Only the benefits and services described in the Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor the plan will pay for benefits or services.**
- I understand that as a member of these plans, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.
- II understand that I can be enrolled in only one Medicare Advantage plan at a time. Enrollment in these plans will automatically end my enrollment in any other Medicare Advantage or Part D prescription drug plans. I am responsible for informing the plan of any other prescription drug coverage I have or may obtain in the future.
- 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 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:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

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 located at **www.anthem.com/ca/forms**. This form is valid for one year from the signature date.

- A printed form can be requested by contacting Member Services at the telephone number on the back of your ID card. **Sign and return it to the address on the form.**
- If you wish to continue having the authorized representative on your account, a new form is required annually.
- If you have a durable healthcare power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

EGBERT
Jeffrey Markov
9297 Office Park Cir
Ste 110
Elk Grove, CA 95758

Please refer to the Anthem 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 BC Health Insurance Company is a PPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

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