Anthem

CITY OF SAN JOSE CAPITAL OF SILICON VALLEY

Anthem BC Health Insurance Company Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*	
Group sponsor name: **City of San Jose**	Group #: **CAEGR027**
Plan you will join (check ONE box only): Anthem Medicare Preferred (PPO) with Senior Rx Plus ☐ 0PH ☐ 0PH75	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):

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 BC Health Insurance Company. 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 or phone with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by email.

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

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 at **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 this Medicare Advantage with (Part D) prescription drug plan, 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 BC 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 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 Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem BC Health Insurance Company. Benefits and services authorized by Anthem BC Health Insurance Company and 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 BC Health Insurance Company will pay for benefits or services.** • I understand that as a member of this plan, 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. • I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan or Medicare Part D prescription drug plan. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform the plan of any other prescription drug coverage that I have or may obtain in the future. • 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:

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:

CAEGR027
ORS Office
1737 North 1st Street
Suite 600
San Jose, CA 95112

Please refer to the Anthem BC 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 Welcome team number listed in this document to request interpreter services.

Anthem BC Health Insurance Company is an 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 Blue Cross is the trade name of In California: Blue Cross of California, Anthem Blue Cross Partnership Plan, Anthem BC Health Insurance Company and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. In 11 northeastern counties of New York: Anthem Blue Cross is the trade name of Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Insurance Companies, Inc., dba Anthem Blue Cross Retiree Solutions and Anthem Blue Cross HP is the trade name of Anthem HP, LLC. Independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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