

Anthem Blue Cross Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required		
Group sponsor name: City of San Jose	Group #: CAEGR027	
Plan you will join: <input checked="" type="checkbox"/> Senior Secure (HMO) with Senior Rx Plus	Requested effective date of coverage: (___ / ___ / ___) (M M / D D / Y Y Y Y) <small>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.</small>	
FIRST name:	LAST name:	Middle initial:
Birthdate: (MM/DD/YYYY) (___ / ___ / ___)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Phone number: () <input type="checkbox"/> Cell <input type="checkbox"/> 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: _____ <small>Your email address will be used for communications only from Anthem Blue Cross. We will not share your email address.</small>		
Your Medicare information:		
Medicare Number:		
Please read and answer these important questions		
1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," retirement date (month/date/year): _____ If "no," name of retiree: _____ Retiree Medicare ID #: _____		
2. Do you have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____ What are the effective dates of coverage? _____		
3. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide the following information: Name of institution: _____ Address (number and street) and phone number of institution: _____		

4. 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: _____

Please choose a primary care physician (PCP), clinic or health center, and write the name and address below.

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:

- I must keep Medicare Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this Medicare Advantage 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 Senior Secure (HMO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem Blue Cross. Benefits and services authorized by Anthem Blue Cross and contained in my Senior Secure (HMO) 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:

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:

ORS Office

Attn: Tamilynn Imai

1737 North 1st Street, Suite 600

San Jose, CA 95112

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 is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross depends on contract renewal. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Instructions for completing the Pre-member/member authorization form



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

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
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).

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

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

All sensitive information²

OR

Just information about topics checked below.

<input type="checkbox"/> Abortion	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Sexually transmitted illness
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Maternity	<input type="checkbox"/> Substance use disorder ^{1,2}
<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Mental health	<input type="checkbox"/> 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.