MEA Benefits Trust
Member Enrollment/Member Change Form

Anthem BlueCross BlueShield

Section 1: Member/Applicant information

Current Anthem Blue Cross and Blue Shield contract no.	Group no.	Last name	First name	M.I.

Home street address or P.O. Box	City	State	ZIP code

Home phone	Work phone	Email address

Section 2: Change status — Please check type and enter date of change below.

Type of change: ☐ Name change ☐ Delete dependent ☐ Address change Date of change: ____ (MM/DD/YYYY)

Reason for change: ☐ Divorce ☐ Covered by other insurance ☐ Death ☐ Other: _____

Section 3: Membership choice

☐ Group Companion Plan ☐ Blue View Vision

Section 4: Applicant information

Name(s) of person(s) (Last name, first name, M.I.)	Sex	Has insurance other than MEA or Medicare?	Social Security no.	Date of birth (MM/DD/YYYY)
Self	☐ Male ☐ Female	☐ Yes ☐ No		
☐ Legal spouse ☐ Domestic partner	☐ Male ☐ Female	☐ Yes ☐ No		
Dependent	☐ Male ☐ Female	☐ Yes ☐ No		
Dependent	☐ Male ☐ Female	☐ Yes ☐ No		
Dependent	☐ Male ☐ Female	☐ Yes ☐ No		

Section 5: Name of Medicare covered person

Medicare Eligible — To be eligible for the MEA Group Companion Plan you must have both Medicare Parts A and B.
If you are age 65 or older and not eligible for Medicare, please return a copy of your Social Security ineligibility letter in the envelope provided.

Name(s) of Medicare beneficiaries (Last name, first name, M.I.)	Medicare claim no.	Medicare Part A effective date	Medicare Part B effective date	Check all reasons you qualified for Medicare
		(MM/DD/YY)	(MM/DD/YY)	☐ Age 65 ☐ ESRD ☐ Disability* Disability date:
				☐ Age 65 ☐ ESRD ☐ Disability* Disability date:

Section 6: Applicant signature

All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Agreement and Certificate of Coverage.

Member or Applicant signature	Print name	Date (MM/DD/YYYY)
X		

Section 7: Election not to enroll

I do not wish to enroll in a plan. Please check one: ☐ I have other coverage OR ☐ I do not have any other coverage
I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

Member or Applicant signature	Print name	Date (MM/DD/YYYY)
X		

* Provide dates of disability for members under age 65 and enrolled in Medicare.

For questions about Group Companion Plan, please call 1-800-422-4304, or in the Portland area 775-1550.
All questions need to be completed before this application can be processed.