

MEA Benefits Trust Retiree – Vision Application/Change Form



Group no.
008500065

All sections need to be completed before this application can be processed.

Section 1: Applicant Information

Last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no.
Home street address	City	State	ZIP code	Home phone no.
<input type="checkbox"/> Retiree				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Section 2: Reason for Application (Please check one)

New enrollment application
 Cancel coverage
 Change of coverage (e.g. add or delete spouse/dependents/domestic partner)

Section 3: Applicant and Family Information

Add/Remove	Last name	First name	M.I.	Date of birth (MM/DD/YYYY)	Social Security no.	Gender
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Self					<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner					<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female

Section 4: Applicant Signature (if you are enrolling or making changes). Please sign below in either section 4 or 5.

The certificate provides vision benefits only. Review your certificate carefully.

I am requesting coverage for myself and all dependents listed. 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.

Applicant signature X	Date (MMDDYYYY)
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Section 5: Applicant Signature (if you are CANCELLING THE ENTIRE POLICY)

Applicant signature X	Date (MMDDYYYY)
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Please call 1-800-322-9808 with questions regarding enrollment.

Send completed form to: Anthem Blue Cross and Blue Shield
Enrolling and Billing Department
2 Gannett Drive
South Portland, ME 04106

OR Fax to 1-207-822-7526 (Note: if sending by fax, please do not send the original.)