



Anthem Blue Cross and Blue Shield Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*

Group sponsor name: Maine Education Association Benefits Trust (MEABT)	Group #: MEEGR001
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Plan you will join: Anthem Medicare Preferred (PPO) with Senior Rx Plus	Requested effective date of coverage: (__/__/____) (M M / D D / Y Y Y Y) 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.
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FIRST name:	LAST name:	MIDDLE initial:
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Birthdate: (MM/DD/YYYY) (__/__/____)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Phone number: () <input type="checkbox"/> Cell <input type="checkbox"/> Other
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Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:
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Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:	City:	State:	ZIP code:
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Email address: _____

Your email address will be used for communications only from Anthem Blue Cross and Blue Shield. 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, phone call, or text 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 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 **1-844-951-0624**, TTY: **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Race*		Ethnicity*	
<input type="checkbox"/> White	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Not of Hispanic, Latino/a, or Spanish Origin	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Puerto Rican	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Mexican, Mexican American, Chicano/a	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Cuban	
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> I choose not to answer	
<input type="checkbox"/> Japanese	<input type="checkbox"/> I choose not to answer		
<input type="checkbox"/> Korean			
What is your gender? Select one.*		Which of the following best represents how you think of yourself? Select one.*	
<input type="checkbox"/> Woman		<input type="checkbox"/> Lesbian or gay	
<input type="checkbox"/> Man		<input type="checkbox"/> Straight, that is, not gay or lesbian	
<input type="checkbox"/> Non-binary		<input type="checkbox"/> Bisexual	
<input type="checkbox"/> I use a different term: _____		<input type="checkbox"/> I use a different term: _____	
<input type="checkbox"/> I choose not to answer		<input type="checkbox"/> I don't know	
		<input type="checkbox"/> I choose not to answer	

IMPORTANT: Read and sign below:

- 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 (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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield. Benefits and services authorized by Anthem Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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/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:

Anthem Blue Cross and Blue Shield

P.O. Box 173605

Denver, CO 80217-3605

Please refer to the Anthem Blue Cross and Blue Shield *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 and Blue Shield is a PPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC and Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield Retiree Solutions. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia with its affiliate Healthkeepers, Inc., and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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