Anthem

Office Use Only: Date Stamp

Anthem MediBlue (HMO) Optional Supplemental Benefits Package Enrollment Request Form for 2019

Use this form only if you are an existing Medicare Advantage plan member and want to enroll in an Optional Supplemental Benefit (OSB) Package available to you. Optional Supplemental Benefits can be added only during certain times of the year. During AEP from October 15 - December 7, during OSB Open Enrollment Period from December 8 - March 31 or if you are a new member, you can add OSB within the first 90 days of your initial enrollment.

Be sure to complete all appropriate sections, sign where indicated and send to:

Enrollment Processing Center, P.O. Box 659403, San Antonio, TX 78265-9714

Or fax the completed form to: 1-800-833-8554

Section 1: Provide the following information: (Please print clearly.)

Please check which Optional Supplemental Benefits Package you want to enroll in.

☐ Preventive Dental Package
$14.00 per month*

☐ Dental and Vision Package
$26.00 per month*

☐ Enhanced Dental and Vision Package
$38.00 per month*

* This premium is in addition to your monthly plan premium.

Last name	First name	MI	Birth date (mm/dd/yyyy)

Member ID number	Email address *(optional)*

Phone number _ _	Alternate Phone number _ _	County

Permanent residence street address (P.O. Box is not allowed.)	City	State	ZIP code

Mailing/billing address (only if different from your permanent address)	City	State	ZIP code

(*continued on next page*)

Section 2: Please complete this section only if you are changing your current payment method or choosing a payment option for the first time.

You can pay your monthly Optional Supplemental Benefits Package premium by mail or electronic funds transfer (EFT) (automatic bank account deduction) each month. You can also choose to pay your premium by automatic deduction from your Social Security check or Railroad Retirement Board (RRB) check each month.

If you don't select a premium payment option below, you will get a bill each month.

Please select a premium payment option:

☐ **Monthly Bill:** Send me a bill each month.

☐ **Automatic bank deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your first payment.) Please complete steps 1 and 2 below:

1) Account type: ☐ **Checking: (must include a voided check)**
☐ Savings: Must enclose a notice from the financial institution showing account information and bank routing numbers.

2) Please complete the following information for your account:

Account holder name _____ Account number _____

Bank routing number* _____ Bank name _____

(*This is the first 9 digits printed on the lower left corner of your check.)

I authorize the bank above to deduct my monthly premiums

☐ **Automatic deduction from your monthly Social Security or RRB benefit check.**
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

(*continued on next page*)

Member Name _____ & Member ID # _____

Section 3: Please read and sign at the end of this section.

Anthem MediBlue (HMO) is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Anthem Blue Cross and Blue Shield, he/she may be paid based on my enrollment in Anthem MediBlue (HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health 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 and Blue Shield will release my information to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment 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 Medicare beneficiaries aren't covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that beginning on the date Anthem Blue Cross and Blue Shield coverage begins, I must get all of my health care from Anthem Blue Cross and Blue Shield, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem Blue Cross and Blue Shield and other services contained in my Anthem MediBlue (HMO) 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 THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that

1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature required to process.

Applicant Signature or Authorized Representative as described above*	**Today's date**

Desired plan effective date

***Authorized Representative Information Only**

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone number _____ - _____ - _____

Relationship to enrollee

(*continued on next page*)

Member Name _____ & Member ID # _____

Applicant: Please do not complete the following sections.
Agent/Broker: Please complete the following section carefully.

Coverage effective date_____

Direct Sales Reps Only: Complete if you assisted in enrollment.

Print name _____

Tax identification number (10 digits) or agent code (variable) __ __ __ __ __ __ __ __ __ __

Signature _____ Company received date stamp _____

Current Agents/Brokers Only: **Complete all fields.**

Date received from member _____

I helped the member fill out this form ☐ Yes ☐ No

Please check the ID number to use for commission payment:

Agent/Broker's tax ID number __ __ __ __ __ __ __ __ __ __ Code number _____

Agency tax ID number __ __ __ __ __ __ __ __ __ __ Code number _____

Please complete all lines below.

Agent/Broker's

Printed name _____ Agency name _____

Address _____

Phone number _____– _____–_____ Fax number _____– _____–_____

Email address _____

Agent/Broker's signature _____

Anthem Blue Cross and Blue Shield is an HMO 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 Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability in our health programs and activities. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-855-690-7796 (TTY: 711).