Anthem Blue Cross
Health. Join In.

Blue Cross MedicareRx (PDP) Employer Group Health Plan Enrollment Election Form

Please contact Anthem Blue Cross if you need information in another language or format (Large print or Braille).

To enroll in Blue Cross MedicareRx (PDP), please provide the following information:			
Employer or Union name University of California		Group # 175011	
Please write in the name of the plan in which you want to be enrolled		Requested effective date of coverage (__ __/__ __/__ __ __ __) *(M M / D D / Y Y Y Y)* The effective date of enrollment will be the first of the month following the signature date, unless a future date is requested.	
Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.
Birthdate (__ __/__ __/__ __ __ __) *(M M / D D / Y Y Y Y)*	Sex ☐ M ☐ F	Home phone number (____) ____ – _________ Alternate phone number (____) ____ – _________	
Permanent residence street address (P.O. Box is not allowed)			
City		State	ZIP code
Mailing address (only if different from your permanent residence address)			
City		State	ZIP code
E-mail address		Retiree SSN	

Please provide your Medicare insurance information

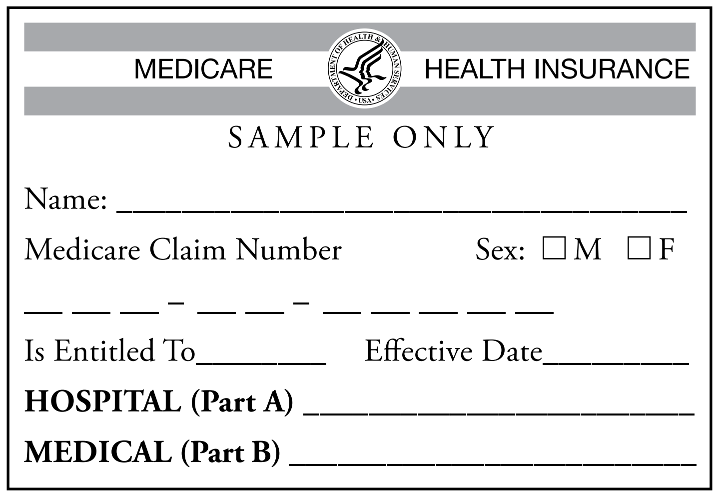
Please take out your red, white and blue Medicare card to complete this section.

- Please fill in these blanks so they match your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ______________________________

Medicare Claim Number Sex: ☐ M ☐ F

__ __ __ – __ __ – __ __ __ __ __

Is Entitled To________ Effective Date_________

HOSPITAL (Part A) ______________________

MEDICAL (Part B) ______________________

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. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If "yes," name of spouse ________________________________

Name of dependents ________________________________

3. Do you or your spouse work? ☐ Yes ☐ No

4. 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: ______________________

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or state pharmaceutical assistance programs.

Will you have [other] prescription drug coverage in addition to Blue Cross MedicareRx (PDP)?

☐ Yes ☐ No

If "yes," please list your [other] coverage and your identification (ID) number(s) for this coverage

Name of other coverage ______________________ ID # for coverage ______________________

6. 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 and phone number of institution (number and street) ________________________________

____

Please read this important information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Blue Cross MedicareRx (PDP), your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Blue Cross MedicareRx (PDP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross MedicareRx (PDP). Please read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

By completing this enrollment application, I agree to the following:

Blue Cross MedicareRx (PDP) is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Cross MedicareRx (PDP) of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Cross MedicareRx (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Election Period (October 15 - December 7), unless I qualify for certain special circumstances.

Blue Cross MedicareRx (PDP) serves a specific service area. If I move out of the area that Blue Cross MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue Cross MedicareRx (PDP) network pharmacies. Once I am a member of Blue Cross MedicareRx (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross MedicareRx (PDP) when I get it to know which rules I must follow in order to get coverage.

I understand that the effective date of enrollment will be the first of the month following the signature date, unless a future date is requested. If I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Blue Cross MedicareRx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross MedicareRx (PDP) 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 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 my signature (or the signature of the person authorized to act on my behalf under State law 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 by Medicare.

Signature	**Today's date**

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

Name ______________________________

Address ______________________________

City ______________________ **State** __________ **ZIP code** __________

Phone number (____) ____ – _________

Relationship to enrollee ______________________

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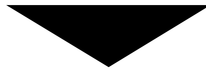
Office use only
Name of staff member/agent/broker *(if assisted in enrollment)* ____________________
Plan ID # ____________________
Effective date of coverage ____________________
ICEP/IEP ______ AEP ______ SEP (type) _____ Not eligible ______

Please return this application to:



Please refer to the Anthem Blue Cross Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

This information is available for free in other languages. Please call First Impressions at the number listed in this book for additional information.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción. M0013_08_014 07/2007

A stand-alone prescription drug plan with a Medicare contract.

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross) has contracted with the Centers for Medicare & Medicaid Services (CMS) to offer the Medicare Prescription Drug Plan(s) (PDPs) noted above or herein. Anthem Blue Cross is the state-licensed, risk-bearing entity offering these plans. Anthem has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs available in this region. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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