Important information regarding your Medicare Advantage plan

✔️ I understand that the effective date of coverage is when I can begin using the plan services, and the Medicare Advantage plan will send me written notification of the effective date of my enrollment in the plan. I understand that this Medicare Advantage plan is offered under a contract with the Centers for Medicare & Medicaid Services (CMS) and CMS' review of its benefits. I understand that my coverage will come into effect only if this enrollment is approved by the plan and CMS.

✔️ I understand that I need to keep my Medicare Parts A & B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.

✔️ I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan of which I am currently a member. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I enroll in a Medicare Part D Prescription Drug plan, it also must be a group sponsored plan. If I enroll in an individual Medicare Part D Prescription Drug plan, it will disenroll me from this group sponsored Medicare Advantage plan.

✔️ I understand that enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year if an enrollment period is available, or under certain special circumstances. I may disenroll from this Medicare Advantage plan by sending a written request to my plan sponsor. Prior to sending a written request, I will discuss my disenrollment with my plan sponsor to ensure that my retiree benefits are not jeopardized. I understand that if I don’t have creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

✔️ I will read the Evidence of Coverage document for this Medicare Advantage plan to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

✔️ This Medicare Advantage plan serves a specific service area, which includes all 50 states, Washington, DC, American Samoa, Guam, Northern Mariana Islands, US Virgin Islands, and Puerto Rico. If I move out of the area the plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree.

✔️ I understand that as a member of this plan, I have the right to ask about the plan's decision about payments or coverage for services I receive, if I disagree.

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 this Medicare Advantage plan will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I understand that if false enrollment information is provided, I will be disenrolled from this Medicare Advantage plan.
Anthem BC Health Insurance Company (Anthem BC Health)
Group-Sponsored Health Plan Enrollment Election Form

To enroll in the Anthem Medicare Preferred (PPO) plan, please provide the following information:

<table>
<thead>
<tr>
<th>Group sponsor name</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laborers Health and Welfare Trust Fund for Northern California</td>
<td>CAEGR010</td>
</tr>
</tbody>
</table>

☑️ Anthem Medicare Preferred (PPO) plan

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.

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birthdate</th>
<th>Sex</th>
<th>Home phone number ( )</th>
<th>Alternate phone number ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ___/__/__/______ ) (M M / D D / Y Y Y Y)</td>
<td>☐ M ☐ F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Permanent residence street address (P.O. Box is not allowed)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Placeholder for Application/Opt-out form]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mailing address (only if different from your permanent residence address)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Email address
Your email address will be used for communications only from Anthem BC Health. We will not share your email address.

Please provide your Medicare insurance information

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

- Please fill out this information as it appears on your Medicare card.
- OR -

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

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

You will need to keep Medicare Parts A and B.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To:  

- Effective Date:  

HOSPITAL (Part A)  

MEDICAL (Part B)
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 have end-stage renal disease (ESRD)?  □ Yes  □ No
If you have had a successful kidney transplant and/or you don’t need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don’t need dialysis; otherwise, we may need to contact you to obtain additional information.

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. Some individuals may have other drug coverage, including other private insurance, Workers’ Compensation, VA benefits or coverage from state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Anthem Medicare Preferred (PPO)?

□ Yes  □ No
If “yes,” please list your other coverage and your identification (ID) number(s) for this coverage.
Name of other coverage __________________________ ID number for coverage __________________________

5. 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 __________________________

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team number listed in this document for additional information.
Please read and sign below

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

Anthem Medicare Preferred (PPO) is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Part A and Part B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform Anthem Medicare Preferred (PPO) of any prescription drug coverage that I have or may get in the future. If my plan does not include prescription drug coverage, I understand that if I don’t have other Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: Annual Election Period from October 15 - December 7) or under certain special circumstances.

Anthem Medicare Preferred (PPO) serves a specific service area. If I move out of the area that Anthem Medicare Preferred (PPO) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Anthem Medicare Preferred (PPO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (EOC) document from Anthem BC Health when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that 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. Beginning on the date Anthem BC Health coverage begins, I must get all of my health care from Anthem BC Health, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Anthem BC Health Insurance Company or Anthem BC Health and other services contained in my Anthem Medicare Preferred (PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ANTHEM BC HEALTH WILL PAY FOR THE SERVICES.

**Release of information:** By joining this Medicare health plan, I acknowledge that Anthem BC Health will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem BC Health 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 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 your application**

<table>
<thead>
<tr>
<th>Applicant signature</th>
<th>Today's date</th>
</tr>
</thead>
</table>

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 ________________________________
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 select “yes” below and complete the HIPAA (Health Insurance Portability and Accountability Act) Pre-Member/Member Authorization Form on the next page and return the HIPAA form to Anthem Blue Cross, PO Box 110, Fond du Lac, WI 54936-0110. This form is valid for one year from the signature date.* If you select “no,” and become a member in the future and wish to complete the HIPAA form, a request can be made by contacting Member Services at the telephone number on the back of your membership card.

☐ Yes  ☐ No

Applicant signature _________________________________ Date ______________

* If you wish to continue having the authorized representative on your account, a new form is required annually.

Please return this application to:

Laborers Funds Administrative Office of Northern California, Inc.
220 Campus Lane
Fairfield, CA 94534-1498

Please refer to the Anthem BC Health Insurance Company Evidence of Coverage (EOC) 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 BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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