

Anthem BC Health Insurance Company Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required

Group sponsor name: Laborers Health and Welfare Trust Fund for Northern California		Group #: CAEGR010	
Plan you will join: <input checked="" type="checkbox"/> Anthem Medicare Preferred (PPO)		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.	
FIRST name:		LAST name:	
Birthdate: (MM/DD/YYYY) (__ / __ / __)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Phone number: () <input type="checkbox"/> Cell <input type="checkbox"/> Other		Middle initial:	
Permanent residence street address (Do not enter a P.O. Box):			
City:		State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed):			
Street address:		City:	State: ZIP code:
Email address: _____ Your email address will be used for communications only from Anthem BC Health Insurance Company. We will not share your email address.			
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 Medicare ID Card, your enrollment into the plan may be delayed.			
Please read and answer these important questions			
1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," retirement date (month/date/year): _____ If "no," name of retiree: _____ Retiree Medicare ID #: _____			
2. Do you have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____ What are the effective dates of coverage? _____			
3. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide the following information: Name of institution: _____ Address (number and street) and phone number of institution: _____			

4. 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 **1-833-848-8729**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays, for additional information or questions you may have.

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 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 BC Health Insurance Company 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) coverage begins, I must get all of my medical benefits from Anthem BC Health Insurance Company. Benefits and services authorized by Anthem BC Health Insurance Company and 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 Insurance Company will pay for benefits or services.**
- 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:

Please return this enrollment election form to:
Laborers Funds Administrative Office of Northern California, Inc.
5672 Stoneridge Drive, Suite 100
Pleasanton, CA 94588

Please refer to the Anthem BC Health Insurance Company *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 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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