Anthem Extras Packages Senior Enrollment Application for CO CT IN KY MO NV OH WI

Anthem BlueCross BlueShield

Send your completed application and payment to:
Anthem Blue Cross and Blue Shield
P.O. Box 5028
Denver, CO 80217-5028
Fax: 1-877-238-1107

In Ohio, underwritten by Community Insurance Company

Corporate address for Kentucky residents:
Anthem Health Plans of Kentucky, Inc.
13550 Triton Park Blvd.
Louisville, KY 40223

Please print – complete in blue or black ink only.

Important: To be eligible to apply for this coverage, you must be 65 years of age or older.

Section A – Applicant Information ******This information is used for internal purposes only and will not be disclosed.*

Last Name	First Name	MI	Social Security Number*

Home Address **(Must be complete. P.O. Box not acceptable)**	City	State	ZIP Code
Mailing Address **(if different from above or for P.O. Box)**	City	State	ZIP Code

County	Gender	Date of Birth	Age	Daytime Phone Number	Evening Phone Number
	☐ M ☐ F	/ /		( )	( )

Email Address (not shared with any third party)	

If you currently have medical or dental coverage through Anthem Blue Cross and Blue Shield, please provide:
Member Identification Number: _____
Effective Date: _____
Termination Date: _____

If you are a current Anthem Blue Cross and Blue Shield member, what insurance do you have with us?

☐ Individual Health ☐ Group Health ☐ Group Vision
☐ Individual Dental ☐ Group Dental

Section B – Coverage Information

Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application.

Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YY).

☐ Standard Package ☐ Premium Package ☐ Premium Plus Package ☐ Premium Plus Dental ***(only)***

Section C – Billing Information

Frequency (select one)	Initial Premium
☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually	☐ Automatic Bank Draft (see below) ☐ Premium Check Enclosed (make check payable to ***Anthem Blue Cross and Blue Shield***) **Total amount enclosed** $ _____

If you submit a personal check for premium payments, you automatically authorize us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

Method (select one)

☐ **HOME –** Bills will be sent to your home address unless you list an alternate address here:

Name _____

Street Address (and P.O. Box, if applicable) _____

City _____ State _____ ZIP Code _____

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the same day of the month as your effective date; ***you must attach a blank, voided check.***

If selecting Automatic Bank Draft: I authorize Anthem Blue Cross and Blue Shield (Anthem) to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. This authorization is in effect until I notify in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals at their discretion.

Account holder's name (please print)

X _____

Account holder's signature (if other than the applicant)

X _____

Section D – Agreement Signature Required

CT CO GA IN KY MO NV OH WI **Fraud Disclaimer:** Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature of Applicant or Legal Guardian or Power of Attorney	Date

Section E – Agent Certification

Agent Information and Declaration: To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation.

Agent Signature	Date

Agent Name (please print)	Agent Street Address/Suite Number/Personal Mailbox (PMB) Number

Writing Agent Tax ID Number	City/State/ZIP Code	County	Area Code

Agent Phone Number	Agent Fax Number	Agent Email Address

Payable Agent/Agency Name (if applicable) (please print)	Payable Agent/Agency Tax ID Number (if applicable)