

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



In Ohio, underwritten by Community Insurance Company

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

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 <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Age	Daytime Phone Number ()	Evening Phone Number ()
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? <input type="checkbox"/> Individual Health <input type="checkbox"/> Group Health <input type="checkbox"/> Group Vision <input type="checkbox"/> Individual Dental <input type="checkbox"/> Group Dental		

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (“BCBSWI”), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (“CompCare”), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

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)

- Monthly Quarterly
- Semi-annually
- Annually

Initial Premium 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)
--	--