

**Anthem Medicare Preferred (PPO) Employer Group Health Plan Enrollment Election Form**

*Please contact Anthem Blue Cross and Blue Shield if you need information in another format, such as large print.*

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

Employer or Union name		Group number	
Please write in the name of the plan in which you want to be enrolled.		Requested effective date of coverage (__/__/____) (MM/DD/YYYY) 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.	
Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birthdate (____/____/____) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ( ) Alternate phone number ( )	
<b>Permanent residence street address</b> (P.O. Box is not allowed)			
City		State	ZIP code
<b>Mailing address</b> (only if different from your permanent residence address)			
City		State	ZIP code
<b>Email address</b>			

**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 and Part B to join a Medicare Advantage plan.

MEDICARE  HEALTH INSURANCE	
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
_____ - _____ - _____	
Is Entitled To _____	Effective Date _____
<b>HOSPITAL (Part A)</b> _____	
<b>MEDICAL (Part B)</b> _____	