

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 ()	
Permanent residence street address (P.O. Box is not allowed)			
City	State	ZIP code	
Mailing address (only if different from your permanent residence address)			
City	State	ZIP code	
Email address			

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 _____		
HOSPITAL (Part A) _____				
MEDICAL (Part B) _____				