RetireeFirst

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

Valley Water

To enroll in Anthem® Group Medicare with Prescription Drug (MAPD) **please provide the following information:**

Desired Effective Date:

Last Name	First Name	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date	Sex	Social Security Number	Home Phone Number
_____ /_____ /_____ *(MM/DD/YYY)*	☐ Male ☐ Female	_____ - ___ - _____	(_____) _____ - _____

Physical Residence Street Address (Cannot be a PO Box):

City:	State:	Zip

Mailing Street Address *(only if different from your Permanent Residence Address)*:

City	State	Zip

Email Address:

Your email address will be used for communications only from the plan and RetireeFirst. We will not share your email address. The email will be used to contact you with Important Plan Information or additional products and services that might interest you. You may change your preference by contacting Member Services.

RetireeFirst

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

  OR

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan

Name: _____

Medicare Claim Number: _____

Is Entitled to:	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

RETIREE MEDICARE-ELIGIBLE PLANS – RETIREE FIRST

Medical / Part D (Rx) – Retiree First

(You must check the box if enrolling in Medical Advantage and Prescription coverage)

Medicare Advantage:

☐ Anthem® Group Medicare Advantage (PPO) plan

Group Number: SCVWDMP1

PLEASE NOTE: This enrollment form is not valid until it is signed and dated on page 5.

RetireeFirst

Please read and answer these important questions:
Are you the retiree? ☐ Yes ☐ No If "yes," retirement date (month/date/year): _____ If "no," name of retiree: _____ Retiree Medicare ID #: _____
Are you currently working? ☐ Yes ☐ No Is your spouse currently working? ☐ Yes ☐ No
Do you have other medical insurance? ☐ Yes ☐ No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____ What are the effective dates of coverage? _____
Do you have other prescription drug coverage (e.g., VA, TRICARE) in addition to this plan? ☐ Yes ☐ No If "yes," what is the name of the health plan?_____ Member number for this Group: _____ What are the effective dates of coverage? _____
Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No If "yes," please provide the following information: Name of institution: _____ Address (number and street) and phone number of institution: _____

This document may be available in an alternate format, such as large print. Please call (855) 347-0939, TTY: 711, hours of operation for additional information or questions you may have.

PLEASE READ THIS IMPORTANT INFORMATION

By completing this enrollment form, I agree to the following:

Release of information: By joining this Medicare Advantage with Part D prescription drug 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 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.

• The Anthem Group Medicare PPO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium

• I understand that I am enrolling into an Anthem Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

•I understand that if I leave this Anthem plan, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service

•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 once my coverage begins, I must receive all medical and prescription drug benefits through Anthem. Only the benefits and services described in the Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor the plan will pay for benefits or services.

•I understand that as a member of this plan, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.

•I understand that I can be enrolled in only one Medicare Advantage plan at a time. Enrollment in this plan will automatically end my enrollment in any other Medicare Advantage or Part D prescription drug plan. I am responsible for informing the plan of any other prescription drug coverage I have or may obtain in the future.

•I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) 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

Individuals experiencing homelessness:

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security benefit checks) may be considered your permanent residence address.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Anthem the Part D-IRMAA.

Signature:	**Today's Date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone Number:	Relationship to enrollee:
For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. Name:_____ Signature:_____	Relationship to enrollee:_____ National Producer Number (Agents/Brokers only):_____

If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form attached

• If you have a durable healthcare power of attorney document, it can also be returned with the HIPAA form