

Anthem® Extras Packages Senior Enrollment Application for Ohio



In Ohio, underwritten by Community Insurance Company

Send your completed application and payment to:
Anthem Blue Cross and Blue Shield
PO Box 5028
Denver, CO 80217-5028
FAX: 1-877-238-1107

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 and not enrolled in a Med Advantage plan with Anthem.

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 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 Dental <input type="checkbox"/> Group Dental				
Language Preference – When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional) <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> Dutch <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Oromo <input type="checkbox"/> Pennsylvania Dutch <input type="checkbox"/> Romanian <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____								
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). <input type="checkbox"/> Standard Package <input type="checkbox"/> Premium Package <input type="checkbox"/> Premium Plus Package <input type="checkbox"/> Premium Plus Dental (only)								

Anthem Blue Cross and Blue Shield is the trade name of: Community Insurance Company.
Independent licensee of the Blue Cross and Blue Shield Association.
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The Blue Cross and Blue Shield name and symbol are the registered marks
of the Blue Cross and Blue Shield Association.

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 \$ _____

Account Type

- Business Checking Business Savings
- Personal Checking Personal Savings

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 Anthem 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 holders name (please print)

X _____

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

X _____

Section D – Agreement Signature Required			
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)	

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apălați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.