

Anthem® Extras Packages Senior Enrollment Application



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

Corporate Address:
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 (Street and P.O. Box if applicable)			City		State	ZIP
County	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Age	Daytime Phone Number ()	Evening Phone Number ()	
E-mail Address (not shared with any third party)						

If you currently have medical, dental or life coverage through Anthem Blue Cross and Blue Shield, please provide your Identification Number : _____	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 <input type="checkbox"/> Group Life/Disability <input type="checkbox"/> Individual Life
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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

Section C–Billing Information

Frequency (select one) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually	Initial Premium (required) <input type="checkbox"/> Automatic Bank Draft (see below) <input type="checkbox"/> Premium Check Enclosed (make check payable to Anthem Blue Cross and Blue Shield) Total amount enclosed \$ _____
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Section C–Billing Information (continued)

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 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 holder's name (please print)

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

X _____**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

Date

Section E–Agent Certification

Agent Signature

Date

Agent Name (please print)

Agent Street Address /Suite No. / Personal Mail Box (PMB) No.

Agent ID No.

City/State/ZIP

County Code

Area

Agent Phone No.

Agent Fax No.

Agent E-mail Address

General Agent (if applicable) (please print)

General Agent Code (if applicable)

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