# Anthem® Extras Packages Senior Enrollment Application for Indiana

Anthem BlueCross BlueShield

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 ☐ M ☐ 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: | If you are a current Anthem Blue Cross and Blue Shield member, what insurance do you have with us? |
|---|---|
| Member Identification Number: _____<br>Effective Date: _____<br>Termination Date: _____ | ☐ Individual Dental ☐ 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)
☐Spanish ☐Arabic ☐Burmese ☐Chinese ☐Dutch ☐French ☐German ☐Hindi ☐Japanese ☐Korean
☐Pennsylvania Dutch ☐Punjabi ☐Russian ☐Tagalog ☐Vietnamese ☐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).

☐ Premium Plus Dental (only)
☐ Standard Package
☐ Premium Package with SilverSneakers/Fitness Program
☐ Premium Package without SilverSneakers/Fitness Program
☐ Premium Plus Package with SilverSneakers/Fitness Program
☐ Premium Plus Package without SilverSneakers/Fitness Program

## 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 |
|---|---|
| Ryan Kennelly | 3501 N Southport #207 |

| Writing Agent Tax ID Number | City/State/ZIP Code | County | Area Code |
|---|---|---|---|
| | Chicago, IL 60657 | COOK | 312 |

| Agent Phone Number | Agent Fax Number | Agent Email Address |
|---|---|---|
| 588-9915 | | ryan@ilhealthagents.com |

| Payable Agent/Agency Name (if applicable) (please print) | Payable Agent/Agency Tax ID Number (if applicable) |
|---|---|
| Illinois Health Agents | 27-0622041 |

# 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 مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (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 ledendienstennummer 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)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (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)

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

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (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)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (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.