OMB No. 0938-1378 Expires: 6/30/2026

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

PLA
Who can use this form? People with Medicare who want to join a Medicare Advantage Plan.
To join a plan, you must: ☐ Be a United States citizen or be lawfully present in the U.S. ☐ Live in the plan's service area
Important: To join a Medicare Advantage Plan, you must also have both: ☐ Medicare Part A (Hospital Insurance) ☐ Medicare Part B (Medical Insurance)
When do I use this form? You can join a plan: □ Between October 15-December 7 each year (for coverage starting January 1) □ Within 3 months of first getting Medicare □ In certain situations where you're allowed to join or switch plans Visit Medicare.gov to learn more about when you can sign up for a plan.
What do I need to complete this form? ☐ Your Medicare Number (the number on your red, white, and blue Medicare card) ☐ Your permanent address and phone number
Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.
Reminders: ☐ If you want to join a plan during fall open enrollment (October 15-December 7), the

plan must get your completed form by

December 7.

Reminders:

Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) Benefit.

What happens next?

Send your completed and signed form to: Anthem HealthKeepers PO Box 659403 San Antonio, TX 78265-9714 Or **fax** to: 1-800-833-8554

You can also enroll **online** at: https://shop.anthem.com/medicare

Once they process your request to join, they'll contact you.

How do I get help with this form? Call Anthem HealthKeepers at 1-866-803-5169. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Anthem HealthKeepers al 1-866-803-5169/711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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 checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0939-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.



Anthem HealthKeepers Individual Enrollment Request Form-2025

Section 1-All fields below are required (unless	•	•	•	•
To add an Optional Supplemental Benefoptions directly below the medical plan	, ,		eck only o	one box from the
□ 051-000 Anthem Medicare Advantag \$19.00 per month	e 3 (HMO-	POS)		
☐ Preventive Dental Package \$22.00 per month**				
☐ Dental and Vision Package \$32.00 per month**				
☐ Enhanced Dental and Vision Pacl \$51.00 per month**	kage			
** This premium is in addition to your mon	thly plan p	remium.		
Last name	First	name		MI (Optional)
Birthdate (MM/DD/YYYY)	Sex □ Male I	□ Female	Phone nu	ımber
Email (Optional)			Alternate	phone number
I want to get the following materials via	email. Sel	ect one or m	ore.	
☐ Benefits updates and legal information s notices; Preapproval or prior authorization			_	•
□ Explanation of Benefits (EOB)				
You can change your communications prefaccount at www.anthem.com or in our Sy		•	logging in	to your online
Permanent residence street address (Do homelessness, a PO Box may be consider	on't enter a	PO Box. Not		
City	State	ZIP co	ode	County (Optional)
Mailing address (only if different from you	r permane	nt address; P	.O. Box all	owed)
City	State	ZIP co	ode	
	1			
Applicant Complete: Name	and	Medicare Nu	mber	
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Your Medicare information				
Medicare Number:				
Please locate the 11-digit alpha-numeric number on your Medicare Card. Example : 1EG4-TE5-MK72				
Effective Date: HOSPITAL (Part A)	MEDICAL (Part B)			

Answer these important questions:					
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Anthem HealthKeepers? □ No					
Name of other coverage:	Member number for this coverage:	Group number for this coverage:	Start Date: (MM/DD/YYYY)	End Date (MM/DD/	
Please choose the name of a primary care physician (PCP). If you do not choose a PCP, we will select a high quality rated provider for you.					
PCP ID # (as shown in the printed or online Provider Directory)					
PCP name					
First Name Last Name					
Primary Medical Group (PMG) name					
PCP address					
City	City State ZIP code				
Are you now seeing or have you recently seen this doctor? □Yes □No					

Section 2 - All fields in this section are optional			
Answering these questions is your choice.			
		se you don't fill them out	<u>t. </u>
Are you Hispanic, Latino/a, or Span	_		
☐ No, not of Hispanic, Latino/a, or Spa	anish origin	☐ Yes, Mexican, Mexican Chicano/a	n American,
☐ Yes, Puerto Rican		☐ Yes, Cuban	
☐ Yes, another Hispanic, Latino/a, or	Spanish origin	☐ I choose not to answ	er
What's your race? Select all that ap			
☐ American Indian or Alaska Native	☐ Black or Af	rican American	
Asian:	Native Hawaii	an and Pacific Islander:	
☐ Asian Indian	☐ Guamania	n or Chamorro	
☐ Chinese	☐ Native Ha	waiian	
□ Filipino	☐ Samoan		
□ Japanese	☐ Other Pac	ific Islander	
□ Korean	☐ White		
□ Vietnamese	☐ I choose n	ot to answer	
☐ Other Asian			
What's your gender? Select one.			
□ Woman	☐ I choose n	ot to answer	
□ Man	☐ I use a diffe	rent term:	
☐ Non-Binary			
Which of the following best represe	nts how you th	ink of yourself? Select o	ne.
☐ Lesbian or gay	☐ I don't knov		not to answer
☐ Straight, that is, not gay or lesbian	☐ I use a diffe	'	
□ Bisexual			
Please check one of the boxes belo	w if you would	prefer us to send you in	formation in
another language or in an accessible	-	protest de la conta you	
□ Spanish			
□ Voice-Enabled (Audio) PDF □ Large Print			
Please contact Anthem HealthKeepers at 1-866-803-5169 if you need information in an			
accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March			
	0 0	,	•
31, and Monday to Friday (except holic	days) irom Aprii	i through September 30.	i i y users can
call 711 .			
Do you work? ☐ Yes ☐ No	Does	s your spouse work?	☐ Yes ☐ No
Would you like to provide your veteran status?			
☐ I am a veteran ☐ I am not a v	/eteran □ I	choose not to answer	
Are you interested in learning more about our Prescription Home Delivery program?			

Applicant Complete: Name

Paying your plan premium

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe, and the optional supplemental benefit plan premium, if you enrolled in that plan) by mail or electronic funds transfer (EFT) each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Anthem HealthKeepers the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month. Please select a premium payment option: ☐ **Monthly Bill:** Send me a bill each month ☐ Automatic Bank Account Deduction: Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your first payment.) Please complete information below: ☐ Checking - May enclose a ☐ Savings - May enclose a letter from financial Account VOIDED check or provide institution with account and routing information Type the following information: or provide the following information: Account holder name Bank name Bank routing number* (*This is the first 9 digits printed on the lower left corner of your check.) Bank account number I authorize the bank above to deduct my monthly premiums. Automatic deduction from your monthly ☐ Social Security or ☐ Railroad Retirement Board (RRB) benefit check. (The Social Security/Railroad Retirement Board (RRB) deduction may take two or more months to begin after Social Security or Railroad Retirement Board (RRB) approves the deduction. In most cases, if Social Security or Railroad Retirement Board (RRB) accepts your request for automatic deduction, the first deduction from your Social Security or Railroad Retirement Board (RRB) benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or Railroad Retirement Board (RRB) delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.) ☐ I want to receive an email notification to access my bill on **www.anthem.com** or in the Sydney Health app instead of having it mailed to me. You can change your billing preference at any time by logging in to your online account at www.anthem.com or in our Sydney Health app.

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Applicant Complete: Name

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H3447 051-000 VA

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions - i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

NOTE: At least one option below needs to be selected. ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
☐ I am new to Medicare. (IEP/ICEP)
☐ I am turning 65 and not new to Medicare. (IEP2)
☐ I recently moved outside my service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) . (SEP)
☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) . (SEP)
☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (SEP)
□ I recently had a change in my Medicaid/Extra Help paying for my Medicare prescription drug coverage (newly got Medicaid/Extra Help, had a change in the level of Medicaid/Extra Help, or lost Medicaid/Extra Help) on (insert date) . (SEP)
☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) . (SEP)
☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) . (SEP)
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) . (SEP)
☐ I am leaving employer or union coverage. Employer/Union coverage started on (insert date) and coverage ends on (insert date) . (SEP)
☐ I belong to a pharmacy assistance program provided by my state. (SEP)
☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) . (SEP)
☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
Applicant Complete: Name
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	I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) (SEP)
	I was recently released from incarceration. I was released on (insert date) (SEP)
	I recently obtained lawful presence status in the United States. I got this status on (insert date) . (SEP)
	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP) Other*
He er Cl	none of these statements apply to you or you're not sure, please contact Anthem ealthKeepers at 1-866-803-5169 (TTY users should call 711) to see if you are eligible to nroll. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and nristmas) from October 1 through March 31, and Monday to Friday (except holidays) from oril 1 through September 30.

Section 3 - IMPORTANT:	Please rea	ad and sign below	1
☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in Anthem Medicare Advantage 3 (HMO-POS).			
By joining this Medicare Advantage Plan, I acknowledge that Anthem HealthKeepers will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.			
☐ I understand that I can be enrolled in only o	□ I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA		
□ I understand that when my Anthem HealthKeepers coverage begins, I must get all of my medical and prescription drug benefits from Anthem HealthKeepers. Benefits and services provided by Anthem HealthKeepers and contained in my Anthem Medicare Advantage 3 (HMO-POS) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Anthem HealthKeepers will pay for benefits or services that are not covered.			
☐ The information on this enrollment 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.			
 I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: This person is authorized under State law to complete this enrollment, and Documentation of this authority is available upon request by Medicare. 			
Signature Required to process your applicat	ion.	•	
Applicant signature X		Today's date	
Desired plan effective date*:			
*Subject to Medicare election period guidelines			
Authorized Representative Information Only			
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.			
Name			
First Name Address		Last Name	
City	State		ZIP code
Phone Number Relationship to Enrollee			
☐ I have submitted Authorized Representati	ive docum	entation with this	application.

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			
Relationship to Enrollee:	Last Name		
☐ Agent ☐ Broker ☐ SHIP counselor ☐ A	uthorized representative ☐ Other ☐ Self		
National Producer Number (Agents/Brokers onl	•		
Signature X			
Applicant: Please do not complete the following sections. Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.			
│ │ □ IEP/ICEP □ AEP □ OEP	□SEP (type): □ Not eligible		
I helped the applicant fill out this application.	□Yes □No		
Scope of Appointment (SOA)			
Appointment type: □Face-to-face	□ Telephone □ Webcam		
How was the scope of appointment (SOA) colle			
□ Paper □ Electronic □ Recorded ca	III (voice recording ID)		
Print name			
Writing Agent encrypted TIN (10 digits)	Last Name		
_			
Agency encrypted TIN (10 digits)			
Agency Name			
Phone Campaign ID			
Email @			
Signature Application received date			
HealthKeepers, Inc. is an HMO-POS plan with a Medicare contract. Enrollment in HealthKeepers, Inc. depends on contract renewal. HealthKeepers, Inc., an independent licensee of the Blue Cross Blue Shield Association, serves all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem is a registered trademark of Anthem Insurance Companies, Inc.			
Translation services are available; please contact the plan or your agent.			

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Section 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Applicant Complete: Name