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

plan must get your completed form by

December 7.

enrollment (October 15-December 7), the

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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield at 1-888-211-9815. 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 Blue Cross and Blue Shield al 1-888-211-9815/711 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 Blue Cross and Blue Shield Individual Enrollment Request Form-2025 Section 1-All fields below are required (unless marked optional). Please check the plan you want to enroll in

To add an Optional Supplemental Benefoptions directly below the medical plan	fits ((OSB) Packa		•	•	
□ 008-000 Anthem Medicare Advantag (PPO) \$39.00 per month	(PPO) \$0.00 p	□ 020-000 Anthem Medicare Advantage				
□ Preventive Dental Package \$25.00 per month**				/e Dental r month**	Package	
 □ Dental and Vision Package \$37.00 per month** □ Enhanced Dental and Vision Package \$60.00 per month** ** This premium is in addition to your monthly plan premium. 			 □ Dental and Vision Package \$37.00 per month** □ Enhanced Dental and Vision Package \$60.00 per month** 			
		** This pr	** This premium is in addition to your monthly plan premium.			
Last name		First name			MI (Optional)	
Birthdate (MM/DD/YYYY)	Sex	∕Male □ Fem	ale	Phone n	umber	
Email (Optional)				Alternate	e phone number	
I want to get the following materials via ☐ Benefits updates and legal information s notices; Preapproval or prior authorization ☐ Explanation of Benefits (EOB) You can change your communications pref account at www.anthem.com or in our Sys	uch notif ferer	as Annual No fication; Enro nces at any ti	otices (Ilment	of Change notification	ns; Bill pay reminders	
Permanent residence street address (Do homelessness, a PO Box may be consider	n't e	enter a PO B				
City	S	tate	ZIP co	ode	County (Optional)	
Mailing address (only if different from you	r pe	rmanent addı	ess; P	.O. Box al	llowed)	
City	S	tate	ZIP co	ode		
Applicant Complete: Name		_ and Medic	are Nu	mber		
Y0114_25_3008726_0000_R_C CMS App Page 1 of 9	rove	ed 08/30/2024	ļ		76MUSENMUB_0159 _008-000_020-000_W	

Your Medicare information					
Medicare Number:	<u> </u>				
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:					

Answer these important questions:					
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Anthem Blue Cross and Blue Shield? □ Yes □ No					
Name of other coverage:	Member number for this coverage:	Group number for this coverage:	Start Date: (MM/DD/YYYY)	End Date: (MM/DD/YYYY)	
Please choose the	e name of a primar	y care physician (F	PCP). (Optional)		
PCP ID # (as shown in the printed or online Provider Directory)					
PCP name					
First Name Last Name				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					

Answering these questions is your choice. You can't be denied coverage because you don't fill them out. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. No, not of Hispanic, Latino/a, or Spanish origin	Section 2 - All fields in this section are optional				
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. No, not of Hispanic, Latino/a, or Spanish origin Yes, Nexican, Mexican American, Chicano/a Yes, Puerto Rican Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer What's your race? Select all that apply. American Indian or Alaska Native Asian: Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Pacific Islander What's your gender? Select one. Woman Man Nan Horose not to answer I choose not to answer					
No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, Chicano/a Yes, Puerto Rican Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer What's your race? Select all that apply. Black or African American Native Hawaiian and Pacific Islander: Guamanian or Chamorro Native Hawaiian and Pacific Islander: Guamanian or Chamorro Native Hawaiian Samoan Japanese I choose not to answer White I choose not to answer White I choose not to answer I choose not to answer				•	
Yes, Puerto Rican		_			
Yes, Amother Hispanic, Latino/a, or Spanish origin	☐ No, not of Hispanic, Latino/a, or Spa	anish origin		n American	1,
Yes, another Hispanic, Latino/a, or Spanish origin □ I choose not to answer What's your race? Select all that apply. □ Black or African American Native Hawaiian and Pacific Islander: □ Guamanian or Chamorro □ Chinese □ Native Hawaiian □ Samoan □ Samoan □ Other Pacific Islander □ Other Pacific Islander □ Other Pacific Islander □ Other Pacific Islander □ Other Asian □ I choose not to answer	□ Vos Buorto Pican				
What's your race? Select all that apply. □ American Indian or Alaska Native Asian: □ Black or African American Asian Indian □ Chinese □ Native Hawaiian and Pacific Islander: □ Chinese □ Native Hawaiian □ Chamorro □ Chinese □ Native Hawaiian □ Chamorro □ Ilipino □ Samoan □ Other Pacific Islander □ Korean □ White □ I choose not to answer □ Other Asian □ I choose not to answer □ What's your gender? Select one. □ I choose not to answer □ Won-Binary □ I choose not to answer □ White □ I choose not to answer □ I don't know □ I choose not to answer □ I don't know □ I choose not to answer □ I don't know □ I choose not to answer □ I use a different term: □ I choose not to answer □ I don't know □ I choose not to answer □ I sease check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: □ Voice-Enabled (Audio) PDF □ Large Print Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 w		Snanish origin		۵r	
American Indian or Alaska Native Asian:				<u> </u>	
Asian Indian		1 -	rican American		
□ Chinese □ Native Hawaiian □ Japanese □ Other Pacific Islander □ Vietnamese □ I choose not to answer □ Other Asian □ I choose not to answer □ Woman □ I choose not to answer □ Non-Binary □ I use a different term: □ Which of the following best represents how you think of yourself? Select one. □ Lesbian or gay □ I don't know □ I choose not to answer □ Straight, that is, not gay or lesbian □ I use a different term: □ Bisexual Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: □ Voice-Enabled (Audio) PDF □ Large Print Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work? □ Yes □ No Does your spouse work? □ Yes □ No Would you like to provide your veteran status? □ I am a veteran □ I am not a veteran □ I choose not to answer Are you interested in learning more about our Prescription Home Delivery □ Yes	Asian:	Native Hawaii	an and Pacific Islander:		
Filipino	☐ Asian Indian	☐ Guamania	an or Chamorro		
□ Japanese □ Other Pacific Islander □ Korean □ White □ Other Asian □ I choose not to answer What's your gender? Select one. □ I choose not to answer □ Man □ I use a different term: □ Non-Binary □ I use a different term: Which of the following best represents how you think of yourself? Select one. □ Lesbian or gay □ I don't know □ Straight, that is, not gay or lesbian □ I use a different term: □ Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: □ Voice-Enabled (Audio) PDF □ Large Print Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work? □ Yes □ No Does your spouse work? □ Yes □ No Would you like to provide your veteran □ I choose not to answer	☐ Chinese	☐ Native Ha	waiian		
☐ Korean ☐ White ☐ Other Asian ☐ I choose not to answer ☐ Other Asian ☐ I choose not to answer ☐ Woman ☐ I choose not to answer ☐ Man ☐ I use a different term: ☐ Non-Binary ☐ I don't know ☐ I choose not to answer ☐ Lesbian or gay ☐ I don't know ☐ I choose not to answer ☐ Straight, that is, not gay or lesbian ☐ I use a different term: ☐ Bisexual ☐ I use a different term: Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: ☐ Voice-Enabled (Audio) PDF ☐ Large Print Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work? ☐ Yes ☐ No Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No Would you like to provide your veteran ☐ I choose not to answer Are you interested in learning more about our Prescription Home Delivery ☐ Yes	□ Filipino	☐ Samoan			
□ Vietnamese □ I choose not to answer □ What's your gender? Select one. □ I choose not to answer □ Moman □ I use a different term: □ Non-Binary □ I use a different term: □ Lesbian or gay □ I don't know □ Straight, that is, not gay or lesbian □ I use a different term: □ Bisexual Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: □ Voice-Enabled (Audio) PDF □ Large Print □ Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work? □ Yes □ No Does your spouse work? □ Yes □ No Would you like to provide your veteran status? □ I am a veteran □ I am not a veteran □ I choose not to answer	□ Japanese	☐ Other Pac	ific Islander		
Other Asian	☐ Korean	□ White			
What's your gender? Select one. □ Woman □ I use a different term: □ I use a different term: □ Which of the following best represents how you think of yourself? Select one. □ Lesbian or gay □ I don't know □ I choose not to answer □ Straight, that is, not gay or lesbian □ Bisexual Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: □ Voice-Enabled (Audio) PDF □ Large Print Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work? □ Yes □ No Does your spouse work? □ Yes □ No Would you like to provide your veteran status? □ I am a veteran □ I am not a veteran □ I choose not to answer	☐ Vietnamese	☐ I choose n	ot to answer		
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□ Man □ I use a different term: □ Non-Binary Which of the following best represents how you think of yourself? Select one. □ Lesbian or gay □ I don't know □ I choose not to answer □ Straight, that is, not gay or lesbian □ I use a different term: □ Bisexual Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format: □ Voice-Enabled (Audio) PDF □ Large Print Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work? □ Yes □ No Do you work? □ Yes □ No ■ I am a veteran □ I am not a veteran □ I choose not to answer Are you interested in learning more about our Prescription Home Delivery		1			
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Please contact Anthem Blue Cross and Blue Shield at 1-888-211-9815 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 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711. Do you work?	another language or in an accessible	e format:			
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Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No Would you like to provide your veteran status? ☐ I am a veteran ☐ I am not a veteran ☐ I choose not to answer Are you interested in learning more about our Prescription Home Delivery					
Do you work? □ Yes □ No Does your spouse work? □ Yes □ No Would you like to provide your veteran status? □ I am not a veteran □ I choose not to answer Are you interested in learning more about our Prescription Home Delivery		days) from April	1 through September 30.	TTY users	can
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□ I am a veteran □ I am not a veteran □ I choose not to answer Are you interested in learning more about our Prescription Home Delivery □ Yes	Do you work? ☐ Yes ☐ No	Does	s your spouse work?	□Yes	□No
Are you interested in learning more about our Prescription Home Delivery	Would you like to provide your veteran status?				
1 1146	☐ I am a veteran ☐ I am not a v	reteran □ I	choose not to answer		
	1 1146				

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 Blue Cross and Blue Shield the Part D-IRMAA.

Oross and blue official the Fart B-It (W/V).				
If you don't selec	ct a payment option, you will get a bill each month.			
Please select a	premium payment option:			
☐ Monthly Bill:	: Send me a bill each month			
each month.	Bank Account Deduction: Electronic funds transfer (EFT) from my bank account (Depending on when you apply, more than one month's amount might be your first payment.) Please complete information below:	t		
Account D Type	☐ Checking - May enclose a VOIDED check or provide the following information: ☐ Savings - May enclose a letter from financial institution with account and routing information or provide the following information:			
Account holder	r name Bank name			
Bank routing nu				
Bank account n	(*This is the first 9 digits printed on the lower left corner of your check.) number			
I authorize the	ne 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.				

1070776MUSENMUB_0159 H4036_008-000_020-000_WI

Applicant Complete: Name

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
Y0114_25_3008726_0000_R_C CMS Approved 08/30/2024

	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*
Cr to Cl	none of these statements apply to you or you're not sure, please contact Anthem Blue coss and Blue Shield at 1-888-211-9815 (TTY users should call 711) to see if you are eligible enroll. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and pristmas) from October 1 through March 31, and Monday to Friday (except holidays) from oril 1 through September 30.

Section 3 - IMPORTANT: Please read and sign below					
 I must keep both Hospital (Part A) and Medical (Part B) to stay in Anthem Medicare Advantage 3 (PPO) or Anthem Medicare Advantage (PPO). By joining this Medicare Advantage Plan, I acknowledge that Anthem Blue Cross and Blue 					
Shield will share my information with Medica make payments, and for other purposes allo of this information (see Privacy Act Stateme	Shield 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				
☐ I understand that I can be enrolled in only o	voluntary. However, failure to respond may affect enrollment in the plan. 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 PEES, MA MSA plans).				
□ I understand that when my Anthem Blue Cross and Blue Shield coverage begins, I must get all of my medical and prescription drug benefits from Anthem Blue Cross and Blue Shield. Benefits and services provided by Anthem Blue Cross and Blue Shield and contained in my Anthem Medicare Advantage 3 (PPO) or Anthem Medicare Advantage (PPO) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Anthem Blue Cross and Blue Shield will pay for benefits or services that are not covered.					
The information on this enrollment form is c understand that if I intentionally provide fals from the plan.		,	O .		
 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: 1) This person is authorized under State law to complete this enrollment, and 					
 Documentation of this authority is availal Signature Required to process your application 		squoot by Wouldard	,		
Applicant signature		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 Last Name Address					
City	State		ZIP code		
Phone Number Relationship to Enrollee					
☐ I have submitted Authorized Representative documentation with this application.					
Applicant Complete: Name					

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	y):			
Signature X				
Agent/Broker: Please fill in ALL fields incluassigned Encrypted ID, Code, or Tax ID I	mplete the following sections. uding 'Writing Agent' and 'Agency' with your pased on your appointed brand, state AND duct.			
□IEP/ICEP □AEP □OEP	□ SEP (type): □ Not eligible			
I helped the applicant fill out this application. Scope of Appointment (SOA)	□Yes □No			
Appointment type: ☐Face-to-face	□Telephone □Webcam			
How was the scope of appointment (SOA) colle				
□ Paper □ Electronic □ Recorded ca	II (voice recording ID)			
Print name First Name	Last Name			
Writing Agent encrypted TIN (10 digits)	<u> </u>			
Agency encrypted TIN (10 digits)				
Agency Name				
Phone	Campaign ID			
Email @ _				
Signature Application received date				
Anthem Blue Cross and Blue Shield is an PPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI) and Compcare Health Services Insurance Corporation. BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare. Compcare underwrites or administers HMO or POS policies. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.				
Out-of-network/non-contracted providers are under no obligation to treat Anthem Blue Cross and Blue Shield members, except in emergency situations. Please call our customer service number				
Applicant Complete: Name				
Y0114_25_3008726_0000_R_C CMS Approved Page 8 of 9	08/30/2024 1070776MUSENMUB_0159 H4036_008-000_020-000_WI			

or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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