Anthem

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Anthem Blue Cross Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*

Group sponsor name:	Group #:
LACERS	**CA013GRX**

Plan you will join:

- ☐ **Part B-only PPO members PDP (5/25/50)**
- ☐ **Part B-only HMO members PDP (5/25/50)**
- ☐ **Life & Health Medicare Plan (Medicare Supplement) PDP (5/25/50)**

Requested effective date of coverage:
(__ __/__ __/__ __ __ __)
(M M / D D / Y Y Y Y)

Generally, the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.

FIRST name: LAST name: Middle initial:

Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other

Permanent residence street address (Do not enter a P.O. Box):

City:	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address: City: State: ZIP code:

Email address:_____

Your email address will be used for communications only from Anthem Blue Cross. We will not share your email address. Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email, phone call, or text with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by ☐ email and/or ☐ text? Messaging and data rates may apply.

Please know you can change your preference at any time by visiting www.anthem.com/ca or contacting customer service.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out:

Race*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander
- ☐ I choose not to answer

Ethnicity*

- ☐ Not of Hispanic, Latino/a, or Spanish Origin
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish Origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Your Medicare information:

Medicare Number: _____

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your Medicare ID Card, your enrollment into the plan may be delayed.

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If "yes," retirement date (month/date/year): _____

If "no," name of retiree:_____ Retiree Medicare ID #:_____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of institution:_____

Address (number and street) and phone number of institution:_____

_____

3. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

Please read this important information:

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Blue Cross MedicareRx (PDP) with Senior Rx Plus, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from a group sponsor, joining Blue Cross MedicareRx (PDP) with Senior Rx Plus could affect your group sponsor health benefits. You could lose your group-sponsored health coverage if you join Blue Cross MedicareRx (PDP) with Senior Rx Plus. Please read the communications your group sponsor sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-866-646-2436**, TTY: **711**, Monday through Friday, 5 a.m. to 6 p.m. PT, except holidays for additional information or questions you may have.

IMPORTANT: Read and sign below:

- I must keep Medicare Part A and Part B to stay in the plan I have selected.
- **Release of information:** By joining this prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Anthem Blue Cross will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- The information on this enrollment election 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

- I understand that when my Blue Cross MedicareRx (PDP) with Senior Rx Plus coverage begins, I must get all of my prescription drug benefits from Anthem Blue Cross. Benefits and services authorized by Anthem Blue Cross and contained in my Blue Cross MedicareRx (PDP) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem Blue Cross will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. 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 election form, and
    2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Please return this enrollment election form to:

Los Angeles City Employees' Retirement System (LACERS)
Attn: Health Benefits Administration Division
P.O. Box 512218
Los Angeles, CA 90051-0218

Please refer to the Anthem Blue Cross *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

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