MEA Health Plans
Member Enrollment/Member Change Form

Anthem BlueCross BlueShield

Section 1: Employer information

Company name			Group no. (if existing group)
Address	City	State	ZIP code
Date of hire (MM/DD/YYYY)	Date of rehire (if applicable) (MM/DD/YYYY)	Date eligible (MM/DD/YYYY)	No. hours worked per week

Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

Section 2: Member/applicant information

Current Anthem Blue Cross and Blue Shield (Anthem) contract no., if any	Last name	First name	M.I.
Home address no., street or P.O. Box and apt. no.	City	State	ZIP code
Home phone	Work phone	Email address	Please check one ☐ Other: _____ ☐ Active employee ☐ Retired employee ☐ COBRA

Section 3: Reason for member enrollment — Please check the reason below and date if required.

☐ Annual enrollment ☐ New group (Initial enrollment) ☐ COBRA – start date: ____ COBRA – event date: ____
☐ New hire ☐ Portability or qualifying life event ☐ Retiree – date of retirement: ____ ☐ Other: _____

Section 4: Change status — Please check type and date of change below.

☐ Name change ☐ Add dependent ☐ Delete dependent ☐ Address change ☐ PCP change — Date of change (MM/DD/YYYY)

Reason for change

☐ Adoption	☐ Annual enrollment	☐ Birth	☐ Court order
☐ Court order changing custody	☐ Covered by Medicaid	☐ Covered by other insurance	☐ Death
☐ Discharge from the military	☐ Divorce	☐ Entrance to the military	☐ Involuntary loss of coverage
☐ Involuntary loss of Medicaid	☐ Marriage	☐ Other: _____	

Section 5: Membership choices

☐ Standard ☐ Choice Plus ☐ Standard $500 Plan ☐ Standard $1,000 Plan

Notice: There are hospitals, health care facilities, physicians or other health care providers who are not included in this plan's network. Your financial responsibilities for payment of covered services may differ if you use a network provider or a non-network provider. Please refer to the online provider directory available at anthem.com to determine if a particular provider is in the network, or contact Customer Service for assistance.

Section 6: Member information — List only dependents you wish to enroll, delete or change.

You may apply to cover your legal spouse, domestic partner (a completed Affidavit of Domestic Partnership must also be attached to this application) and children/stepchildren to age 26.

Name(s) of person(s) (Last name, first name, M.I.)	Sex	Has other insurance?	If disabled, when?	Social Security no.[1] (required)	Date of birth (MM/DD/YYYY)	Primary Care Physician (PCP)[2] (See below for instructions)	Current patient
Self	☐ M ☐ F	☐ Yes ☐ No				Name / PCP no.	☐ Yes ☐ No
☐ Legal spouse ☐ Domestic partner	☐ M ☐ F	☐ Yes ☐ No				Name / PCP no.	☐ Yes ☐ No
Dependent	☐ M ☐ F	☐ Yes ☐ No				Name / PCP no.	☐ Yes ☐ No
Dependent	☐ M ☐ F	☐ Yes ☐ No				Name / PCP no.	☐ Yes ☐ No
Dependent	☐ M ☐ F	☐ Yes ☐ No				Name / PCP no.	☐ Yes ☐ No

1 Anthem is required by the Internal Revenue Service to collect this information.
2 If applying for Choice Plus, each member must fill in PCP information. For current listing of valid PCPs, go to the HMO Choice network at anthem.com. If applying for Standard, do not complete this section.

Section 6: Member information (continued) — List only dependents you wish to enroll, delete or change.

Are you or any family members currently claiming Workers' Compensation Medical Benefits? ☐ Yes ☐ No

If yes, name of claimant: _____

Section 7: Prior coverage information — This section must be completed.

Have you or any other family member had health insurance coverage in the 90 days prior to your date of hire or the effective date of your new policy? ☐ Yes ☐ No
If yes, please complete the following:

	Self	Legal spouse/ Domestic partner	Dependents		
			1	2	3
Name of insurance company					
Certificate (policy) no.					
Date coverage began					
Date coverage ended or is coverage still in effect?					

Section 8: Medicare beneficiaries information

Is anyone listed on this application currently eligible for Medicare? ☐ Yes ☐ No
If yes, please complete the following for each person to be covered who is eligible for or covered by Medicare.

Name(s) of Medicare beneficiaries	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date	Check all reasons you qualified for Medicare
					☐ Age 65 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD

Section 9: Applicants — Only complete this section if you are requesting coverage.

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the *Group Agreement* and *Certificate of Coverage*. I understand that each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) (does not apply to Standard) except as described in my *Certificate of Coverage*.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

W-9 Certification Language: I certify each Social Security number listed on this application is correct.

My signature on this application constitutes my approval and authorization for Anthem to enforce its subrogation rights for my claims on a just and equitable basis.

Applicant signature **X**	Print name	Date (MM/DD/YYYY)

Section 10: No coverage — Complete this section if you do not want coverage.

I do not wish to enroll in a plan. Please check one: ☐ I have other coverage **OR** ☐ I do not have any other coverage
I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem.

Applicant signature **X**	Print name	Date (MM/DD/YYYY)

For questions about MEA Choice Plus or MEA Standard,
please call 1-800-527-7706, or in the Portland area, 1-207-822-8282.
All questions need to be completed before this application can be processed.