Anthem® Extras Packages Senior Enrollment Application for Missouri

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. PO Box not acceptable)	City	State	ZIP Code
Billing Address (if different from above or for PO Box)	City	State	ZIP Code
Mailing Address (if different from above or for PO 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 any carrier including Anthem Blue Cross and Blue Shield, please provide:

Name of Carrier_____ Member Identification Number_____

Effective Date_____ Termination Date_____

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 ☐Amharic ☐Arabic ☐Chinese ☐Farsi ☐French ☐German ☐Korean ☐Oromo ☐Pennsylvania Dutch
☐Portuguese-Europe ☐Russian ☐Serbian ☐Tagalog ☐Vietnamese ☐Other _____

Section B – Coverage Information

Effective date requested: If your application is approved, your coverage can start on any day (between the 1st-25th) of the month after the date we receive your application.

Please choose the date (between the 1st-25th) 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 is deducted on the same day of the month as your effective date, if the draft date is not indicated.
Draft Date: _____ Draft dates available are the 1st-25th of the month.

☐ 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, if draft date is not indicated in Section C; ***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.

I also understand if changes I make to my auto withdrawal amount are processed close to the withdrawal date, Anthem may not be able to notify me of the new auto withdrawal amount before the withdrawal is made.

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

Writing Agent Tax ID Number	City/State/ZIP Code	County

Agent Phone Number	Agent Fax Number	Agent Email Address

Payable Agent/Agency Name (if applicable) (please print)	Payable Agent/Agency Tax ID Number (if applicable)