ID #: _____
Firm #: _____
Effective Date: _____

Medicare Supplemental Selection Form

Anthem

Please complete this form if you are electing Group Medicare Supplemental Coverage.

Name _____
(last) (first) (initial)

Address _____
(street) (city) (state) (zip code)

Date of Birth _____ Sex ☐ Male ☐ Female
(mo) (day) (year)

Subscriber No. _____

Name and Address of Employer _____

_____

Firm/Division Number _____

Medicare Number _____
(from your Medicare Card)

Part A (Hospital) Effective Date _____

Part B (Medical) Effective Date _____

Part D (Drug) Effective Date (if elected) _____

(Please attach a copy of your Medicare Card)

Note: You must retain both Parts A & B of Medicare in order to remain eligible for this Medicare Supplemental Coverage. Depending on the coverage selected by your group, you may be required to retain Medicare D in order to remain eligible for this Medicare Supplemental Coverage.

Are you eligible for Medicare due to End Stage Renal Disease? ☐ Yes ☐ No

If applicable, please indicate the date on which you retired. _____
(mo) (day) (year)

Will your dependents remain on your Anthem coverage? ☐ Yes ☐ No

Signature _____ Date _____

If you have any questions, please call our Customer Service Representative at the number on your ID card.

(For Office Use Only)
☐ Add Initials _____
☐ Transfer