For office use only:
______VRS-78 ______ Benefits Dept.
Input Date: ________________
Munis Code : 8201
______ Manual Check

ANTHEM BCBS – NON-Medicare B eligible RETIREE HEALTH ENROLLMENT APPLICATION

Please complete in ink and return to SCPS. Use extra sheets of paper if necessary.

Group Name: Stafford County Public Schools Group Number: 048144- MR________ Retirement Date ______________

RETIREE INFORMATION – SECTION 1

Effective Date: (Mo/ Day/ Yr) _____________ Initials _____ (Required field to be completed by Retiree Participant)

Last name: ________________________________ First name ________________________________ M.I.__________

Social security # ________________________ Date of birth (MM/DD/YYYY) ________________ Sex: ❑ M ❑ F

Street address ____ Apt. # ________

City ____ State___________ Zip____________

Daytime phone (with area code) (_________) ____

REASON FOR APPLICATION – SECTION 2

❑ Enroll / new ❑ Remove dependent
❑ Change coverage

❑ Married
❑ Single

PLAN SELECTION – SECTION 3

❑ Premium Plan – (MR01) ❑ Core Plan – (MR05)

TYPE OF COVERAGE – SECTION 4

❑ Retiree only ❑ Retiree / spouse ❑ Retiree / one child
❑ Retiree / children ❑ Retiree / family

FAMILY INFORMATION – SECTION 5

*For additional children, include information on separate sheet of paper and attach to application. * If a dependent is disabled or handicapped before age 26, please attach physician certification.*

Name (First, M.I., Last if different)	Relation Spouse, Son, daughter, stepson, etc.	M / F	Social Security #	Date of Birth MM/DD/YYYY	Disabled before age 23? Y / N *	Full-time student? Y / N

Other Insurance Information – Section 6

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name: ____ Policy/ID number: ______________
Address of other coverage: ____
City: ____ State: _____________ Zip: ______________
Phone number of other carrier/plan: (_______) ______________________ Effective date (MM/DD/YY) ____________
Policyholder name (Last, First, M.I.) ____
Please indicate whom this coverage applies to (check all that apply):

❑ Self ❑ Spouse ❑ All Children ❑ Child: Last Name _________________________ First Name ______________

Do you intend to continue this coverage? ❑ Yes: Please provide policyholder's date of birth: ______________________

Type of coverage: ❑ Health ❑ Dental

❑ No: Please provide cancellation date of coverage: _________________________________

Retiree Participant CERTIFICATION – SECTION 8

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under the policy. I understand that it is discovered that I provided false or misleading information to Anthem Blue Cross Blue Shield within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.
The retiree and any person authorized to act on behalf of the retiree, are entitled to receive a copy of this form and will be provided with a copy upon their request.

Retiree Signature: ____ Date: ________________