

State of Maine Blue View Vision Retiree Application/Change Form

All sections need to be completed before this application can be processed.



Section 1: Applicant information

| | | | | | | |
|--------------|---|--------------------------|--|--|---------------------|----------|
| Last name | | First name | | M.I. | Social Security no. | |
| Home address | | City | | | State | ZIP code |
| Home phone | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (MMDDYYYY) | | Anthem Blue View Vision ID no. (if applicable) | | |

Section 2: Reason for application – Please check one

| | |
|---|-------------------------------|
| <input type="checkbox"/> Retiree | Date of retirement (MMDDYYYY) |
| <input type="checkbox"/> New enrollment application | Effective date (MMDDYYYY) |
| <input type="checkbox"/> Cancel coverage | Effective date (MMDDYYYY) |
| <input type="checkbox"/> Change of coverage (e.g. add or delete spouse/dependents/domestic partner) | Effective date (MMDDYYYY) |

Section 3: Qualifying life event

Marriage Divorce Other: _____

Section 4: Applicant and family information

| Add/Remove | Last name | First name | M.I. | Birth date (MMDDYYYY) | Social Security no. | Gender |
|---|---|------------|------|-----------------------|---------------------|--|
| <input type="checkbox"/> Add <input type="checkbox"/> Remove | Self | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| <input type="checkbox"/> Add <input type="checkbox"/> Remove | <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| <input type="checkbox"/> Add <input type="checkbox"/> Remove | Dependent | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| <input type="checkbox"/> Add <input type="checkbox"/> Remove | Dependent | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| <input type="checkbox"/> Add <input type="checkbox"/> Remove | Dependent | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |

Section 5: Applicant signature (if you are enrolling or making changes). Please sign below in either section 5 or 6.

The certificate provides vision benefits only. Review your certificate carefully.

I am requesting coverage for myself and all dependents listed. 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.

| | |
|---------------------------------|-----------------|
| Applicant signature X | Date (MMDDYYYY) |
|---------------------------------|-----------------|

Section 6: Applicant signature (if you are cancelling the entire policy)

| | |
|---------------------------------|-----------------|
| Applicant signature X | Date (MMDDYYYY) |
|---------------------------------|-----------------|

Please call 800-322-9808 with questions regarding enrollment.

Send completed form to: Anthem Blue Cross and Blue Shield
Enrolling and Billing Department
2 Gannett Drive
South Portland, ME 04106

OR Fax to 801-252-4292
(Do not send the original if sending by fax.)