



To Anthem Blue Cross HMO and Point of Service Enrollees:

Do you have dependents who reside outside of California?

If so, they may be able to enroll for HMO coverage with a partner Anthem Blue Cross Blue Shield plan under our **GUEST MEMBERSHIP** program.

**CALL (800) 827-6422 TO:**

- Verify provider availability in the area where your dependent resides.
- Request a ***Guest Membership*** application
- Assist in submitting your Guest Membership applications and answer any questions that you have along the way.

**PARTICIPATING STATES:**

ARIZONA		ARKANSAS		COLORADO		CONNECTICUT
DELAWARE		FLORIDA		GEORGIA		HAWAII
ILLINOIS		INDIANA		KENTUCKY		LOUISSIANA
MAINE		MARYLAND		MASSACHUSETTES		MICHIGAN
MINNESOTA		MISSOURI		NEVADA		NEW HAMPSHIRE
NEW JERSERY		NEW MEXICO		NEW YORK		NORTH CAROLINA
OHIO		OKLAHOMA		PENNSYLVANIA		RHODE ISLAND
SOUTH CAROLINA		TEXAS		VIRGINIA		WISCONSIN

\*\*THESE STATES MAY HAVE REGIONS THAT ARE NOT COVERED. THEREFORE APPLICANTS CAN STILL BE DENIED COVERAGE IF THE REGION WITHIN THE GUEST STATE DOES NOT HAVE AFHC PROVIDERS\*\*

***THANK YOU FOR CHOOSING ANTHEM BLUE CROSS AS YOUR HEALTH PLAN.***

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# Away from Home Care Guest Membership and Follow-up Care Application

**BlueCross BlueShield  
Association**

An Association of  
Independent BlueCross &  
BlueShield Plans

## A – SUBSCRIBER INFORMATION

<b>Name:</b>		<b>Social Security #</b>	
<b>Address:</b> _____ _____ _____		<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partners <input type="checkbox"/> Married
<b>Telephone: Home:</b>	<b>Work:</b>	<b>Date of Birth:</b>	
<b>Employer Name and Address:</b> _____ _____ _____		<b>Group #</b>	<b>Employment Status:</b> <input type="checkbox"/> Active <input type="checkbox"/> Retired
		<b>Type of Coverage:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family	

## B – GUEST INFORMATION

<b>Relationship to Subscriber:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
<b>Name:</b>		<b>Social Security #</b>	
<b>Address Away From Home:</b> _____ _____ _____		<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partners <input type="checkbox"/> Married
<b>Telephone Away from Home:</b>		<b>Work:</b>	<b>Date of Birth:</b>
<b>Medicare Enrollee?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicare Type:</b> <input type="checkbox"/> Traditional <input type="checkbox"/> Medicare Risk <input type="checkbox"/> Medicare Cost	<b>Medicare #:</b> _____	
<b>Should the Host Plan (Out-of-California Insurance Provider) direct the patient to a Medicare Participating Provider?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			

## C – CONTROL INFORMATION

<b>Period Covered by the Guest Application:</b>	<b>From:</b> _____	<b>To:</b> _____
<small>(Note: Must be between Three to Twelve Months for Spouse and Dependents &amp; Three to Six Months for Subscribers. Must Be Renewed EVERY CALENDAR YEAR.)</small>		
<b>Type of Service (Check One)</b>		
<b>1. Guest Service:</b> <input type="checkbox"/> Families Apart <input type="checkbox"/> Student <input type="checkbox"/> Long-Term Traveler	<b>2. <input type="checkbox"/> Pre-Authorized Follow-Up Care</b>	

I hereby certify that all information stated above is truthful and correct to the best of my knowledge. I acknowledge that the benefit program providing coverage to myself or eligible dependents as guest members of the HOST HMO, may vary from the benefit program at my HOME HMO. I understand that as a guest member, the HOST HMO benefit program's scope and levels of coverage apply. (This does not apply to GM and Ford participants receiving home benefits.)

\_\_\_\_\_  
Subscriber Signature

\_\_\_\_\_  
Date of Application