



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

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

B – GUEST INFORMATION

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

C – CONTROL INFORMATION

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

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