Away From Home Care Guest Membership Application

Subscriber Information **Application Date:**

Name:	Identification Number:
	Social Security Number:
Address:	Home Telephone:
	Work Telephone:
	Date of Birth:
	Gender: Female Male
Employer Name:	Group Number:

B. GUEST MEMBER INFORMATION

NAME:	Social Security Number:
ADDRESS AWAY FROM HOME:	Date of Birth:
_____	Gender: Female Male
_____	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT
_____	Host Telephone :_____

Name of Guardian of Minor Child:_____Relationship:_____

(Guardian information is required for all members under the age of 18.)

MEDICARE ENROLLEE: YES NO MEDICARE ID#_____	Is Medicare Primary?	YES NO
MEDICARE PART:A_____B_____(Enter dates)	Do you have any other insurance?	YES NO
Name of other Insurance carrier:_____Policy Number:_____		

C. CONTROL INFORMATION:

PERIOD OF GUEST MEMBERSHIP NEEDED: FROM:_____ TO:____ _____	NEW RENEWAL
(Please Note:There is a 20 day waiting period on all apps. A confirmation letter will be sent indicating the actual period for Guest Membership.)	
TYPE OF GUEST MEMBERSHIP: FAMILIES APART STUDENT LONG TERM TRAVELER (LIMITED TO 6MONTHS)	

D. AWAY FROM HOME CARE AUTHORIZATION

I hereby certify that all information on this application 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.

_____ _____

SIGNATURE OF SUBSCRIBER DATE

I hereby authorize my Home HMO and my Host HMO, to exchange medical information about me.

_____ _____

Signature of Guest Member(parent/guardian for minor) DATE

Please mail your application to:
Anthem HealthKeepers
Atten: Service Operations-AFHC-VA23S150
P O Box 26623
Richmond, VA 23261

For faster service, application can be faxed to:
804-354-2348