

Enrollment Application

Group size 51+ eligible employees



INSTRUCTIONS:

Please read carefully, complete _____ in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings for HMO/POS plans can be obtained through www.anthem.com

SECTION 1: EMPLOYER/GROUP USE - Required											
Employer name					Employer address						
Group no.		Sub-group no./ Life division no.		Requested effective date		Life classification		Employee no./Dept. name			
SECTION 2: REASON FOR APPLICATION - Required											
<input type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment (N/A to Life)			<input type="checkbox"/> COBRA Qualifying event _____ event date _____ <input type="checkbox"/> Waiver (To decline ALL coverage skip to Section 12)			<input type="checkbox"/> New hire <input type="checkbox"/> Rehire date _____		<input type="checkbox"/> Add dependent (Fill in Section 3)			
SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.											
Event date		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth		<input type="checkbox"/> Adoption (Attach legal documentation) <input type="checkbox"/> Legal guardianship (Attach legal documentation)		<input type="checkbox"/> Loss of coverage (reason) _____ <input type="checkbox"/> Other _____		<input type="checkbox"/> Termed employment			
SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.											
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> Dental To apply for BUY-UP coverage, check PPD and write in the plan number on the line provided. </div> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: 1px solid black; padding: 2px;"> <input type="checkbox"/> DentaCare (HMO)* <input type="checkbox"/> Freestanding (DentalBlue) </td> <td style="width: 50%; border: 1px solid black; padding: 2px;"> Type of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage </td> </tr> </table>										<input type="checkbox"/> DentaCare (HMO)* <input type="checkbox"/> Freestanding (DentalBlue)	Type of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage
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SECTION 5: EMPLOYEE INFORMATION - Required											
Last name			First name			M.I.	Date of birth		Age	Social security no. (required)	
Sex	<input type="checkbox"/> M	<input type="checkbox"/> Single	<input type="checkbox"/> Married	Height	Weight	Home phone		Business phone		Email address	
	<input type="checkbox"/> F	<input type="checkbox"/> Divorced									
Address							City	State	ZIP code	County	
Retired		Disabled		Hospitalized		Occupation		Full-time hire date		Hours working per week	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No					Income reported by <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other _____	
* Complete Primary Care Physician (PCP) information for HMO or POS plans only.											
Anthem PCP name and address							Anthem PCP ID no.		New patient <input type="checkbox"/> Yes <input type="checkbox"/> No		

Employee name _____

Social security no. _____

SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Last name		First name			M.I.	Social security no. (required)	
Date of birth	Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)		
If spouse/DP address is different than employee, please provide full address							
Anthem PCP name and address (for HMO or POS plans only)					Anthem PCP ID no.		New patient <input type="checkbox"/> Yes <input type="checkbox"/> No

Last name		First name			M.I.	Social security no.		Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)			
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)								
If dependent address is different than employee, please provide full address								
Anthem PCP name and address (for HMO or POS plans only)					Anthem PCP ID no.		New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

Last name		First name			M.I.	Social security no.		Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)			
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)								
If dependent address is different than employee, please provide full address								
Anthem PCP name and address (for HMO or POS plans only)					Anthem PCP ID no.		New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

Last name		First name			M.I.	Social security no.		Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)			
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)								
If dependent address is different than employee, please provide full address								
Anthem PCP name and address (for HMO or POS plans only)					Anthem PCP ID no.		New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 8: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? Yes No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company			Policy/certificate no.		Effective date
Policy/certificate holder name		Social security no.		Date of birth	Relationship to employee
Are you and/or your dependents enrolled in Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below.					
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date	
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date	
Medicare Part D ID no.		Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date	
Reason for Medicare entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD & Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)					

Employee name _____

Social security no. _____

SECTION 9: PRIOR HEALTH COVERAGE - Required

Have you and/or your dependents had prior health coverage? Yes No - If yes, complete below.

Have you been covered by Anthem within the past two (2) years Yes No Policy/certificate no. _____

Group name/ID no. _____ Date policy in effect _____ Date policy terminated _____

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years Yes No

List prior carrier(s) _____ Date policy in effect _____ Date policy terminated _____

Please check the type of prior coverage

Employee Employee+Spouse/DP Employee+Child(ren) Employee+Spouse/DP+Child(ren)

Termination reason:

Divorce/legal separation Employment terminated Employer/group contribution ceased Other
 Death of spouse/DP COBRA coverage exhausted Group plan terminated

SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) - Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

- 1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
- 2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
- 3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
- 4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline to this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
- 5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
- 6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

SECTION 11: SIGNATURE - Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature

X

Date

Employee name _____

Social security no. _____

SECTION 12: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
<input type="checkbox"/> Medical	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Dental	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Vision	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Life	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> All	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	

Check all that apply:

I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

Please check if any of the following apply:

- I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- Other: _____

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature X	Date
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