

Enrollment Application

Group size 51+ eligible employees



INSTRUCTIONS:

Please read carefully, complete electronically, or 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 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"/> New hire	<input type="checkbox"/> Add dependent (Fill in section 3)	<input type="checkbox"/> Annual open enrollment (N/A to Life)	<input type="checkbox"/> Rehire – Date: _____
<input type="checkbox"/> COBRA – Qualifying event: _____			COBRA event date: _____	
<input type="checkbox"/> Waiver (To decline ALL coverage skip to section 11.)				

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"/> Terminated employment	<input type="checkbox"/> Other: _____		
If qualifying event is due to loss of coverage, indicate the reason for the loss of coverage: _____				

Section 4: Plan/type of coverage – Required. To decline a plan type, check “No coverage”. If you are waiving all coverage, go to section 11.

Dental – To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.				
<input checked="" type="checkbox"/> No Coverage	<input type="checkbox"/> DentaCare (HMO)	<input type="checkbox"/> Dental Blue® 100		
Type of dental coverage: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse (DP) <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage				

Section 5: Employee information – Required

Last name		First name		M.I.	Social Security no. ³ (required)	
Date of birth (MM/DD/YYYY)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Height	Weight	
Home phone no.		Business phone no.		Email address		
Street address			City	State	ZIP code	County
Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation	Hours working per week	Full-time hire date	Income reported by: <input type="checkbox"/> W-2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____
Anthem PCP name and address				Anthem PCP ID no.	New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

1 Anthem Blue Cross and Blue Shield (Anthem) will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your employer.
 2 Lumenos products with Blue Priority - WI network are offerings of the Well Priority product portfolio.
 3 Anthem is required by the Internal Revenue Service to collect this information.

Employee name

Social Security no.¹ (required)

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 9, Significant Terms, Conditions and Authorizations, prior to answering the questions in section 6.

Spouse/Domestic Partner form with fields for Last name, First name, M.I., Social Security no., Date of birth, Height, Weight, Sex, Relationship to employee, Currently hospitalized or disabled, Anthem PCP name and address, Anthem PCP ID no., New patient?

Dependent form with fields for Last name, First name, M.I., Social Security no., Date of birth, Height, Weight, Sex, Relationship to employee, Currently hospitalized or disabled, Anthem PCP name and address, Anthem PCP ID no., New patient?

Dependent form with fields for Last name, First name, M.I., Social Security no., Date of birth, Height, Weight, Sex, Relationship to employee, Currently hospitalized or disabled, Anthem PCP name and address, Anthem PCP ID no., New patient?

Section 7: Life and disability insurance – Required, if this type of coverage was selected in section 4.

Life and disability insurance form with fields for Current Income, Life Class, Anthem ByDesign Buy-Up, Primary beneficiary, Contingent beneficiary.

Section 8: Other health coverage – Required

Other health coverage form with fields for Do you and/or your dependents have other health coverage?, Provide name, phone number and address of the HMO or insurance company, Are you and/or your dependents enrolled in Medicare or Medicaid?, Reason for Medicare entitlement.

¹ Anthem is required by the Internal Revenue Service to collect this information.

Employee name

Social Security no.¹ (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 9: 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 (Anthem) 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 at any time.

- I understand that I may not assign any payment under my Anthem program.
- I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
- 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.
- 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.
- 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.

I certify each Social Security number listed on this application is correct.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read section 9 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 Date

X

¹ Anthem is required by the Internal Revenue Service to collect this information.
ANI-92 Rev. 6/17

Employee name

Social Security no.¹ (required)

Section 11: 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 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. 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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Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), CompCare Health Services Insurance Corporation (CompCare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare or WCIC; CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Life and Disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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