Enrollment Application

RESET

Anthem Anthem Life

Group size 2-50 eligible employees

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. *All information given should apply to this employer.*

1. TYPE OF COVERAGE REQUESTED: ☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family ☐ Life Only ☐ No coverage

2. ENROLLMENT INFORMATION ☐ Single ☐ Divorced ☐ Married

Relationship	Last Name, First Name, M.I.	Social Security No. Required	Sex	Full Time Student?	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F			/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F			/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F	☐ Yes ☐ No		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F	☐ Yes ☐ No		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F	☐ Yes ☐ No		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No

Employee Home Address: Street, City, State, ZIP Code | County

Employee Home Phone ( ) | Employee Work Phone ( ) | Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) | Dependent Name(s)

3. MEDICAL INFORMATION ***(If yes, circle condition)***

*** Please read the Genetic Information Non-discrimination Act (GINA) information on page 3, section 11, prior to answering the below questions.**

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name _____ due date ____/ ____/ ____
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes **(list age of onset below)**; mental/nervous disorder; depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. LIFE AND DISABILITY INSURANCE

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability
☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability
☐ Optional Life: _____ x annual earnings OR $_____
☐ Current Income: $ _____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

☐ Anthem By Design Short Term Disability BUY-UP
☐ Anthem By Design Long Term Disability BUY-UP
☐ Anthem By Design Basic Life BUY-UP
(Complete separate election form.)

Life Class

	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			_ _		
Contingent Beneficiary			_ _		

5. PLEASE READ THE TERMS IN SECTION 11 CAREFULLY BEFORE SIGNING, AND REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant signature | Please Print Name | Date / /

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Group size 2-50 eligible employees Name: _____ SS#: ____ - ____ - ____

6. PLEASE COMPLETE ALL INFORMATION

Reason for application:
- ☐ New enrollment
- ☐ Open enrollment (N/A for Life coverage)
- ☐ Qualifying event (please complete date and reason)
  Event Date ____/ ____/ ____
  - ☐ Marriage ☐ Divorce
  - ☐ Birth of Child ☐ Adoption
  - ☐ Termed Employment ☐ Other
- ☐ COBRA
  Event _____ Date ____/ ____/ ____
- ☐ State Continuation ☐ Waiver

Group Name	Group number	Sub Group Number
Group Address		Employee Hire/Rehire Date (Full time) / /

Employee status	Hours working per Week	Occupation	Income reported by:
☐ Active ☐ Disabled ☐ Retired ☐ Other (please explain)	If not actively working, reason Projected Return Date ____/ ____/ ____	Annual Salary	☐ W2 ☐ 1099 ☐ Other (please explain)

7. COVERAGE SELECTION *(Availability dependent upon your employer's offering)*

Medical Coverage
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Check the medical plan you are applying for:
- ☐ PPO
- ☐ Anthem Essential℠ PPO
- ☐ HMO (HIC in Ohio)
- ☐ POS (Ohio only)
- ☐ Traditional
- ☐ Blue Access® Hospital Surgical PPO
- ☐ HDHP Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.
- ☐ HDHP/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ PPO/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ Lumenos® Health Savings Account
- ☐ Lumenos® Health Reimbursement Account
- ☐ Lumenos® Health Incentive Account
- ☐ Lumenos® Health Incentive Account Plus

Dental Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Vision Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

1. If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.
2. A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.

8. WAIVER OF COVERAGE SECTION: *(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)*

NOTE: If waiving coverage, please complete this section. Section 5 must also be signed and dated.

Medical Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Dental Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Vision Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Life coverage declined for: ☐ Myself

Reason for Declining Coverage (check all that apply):
- ☐ Covered by spouse's group coverage - Carrier name and ID Number _____
- ☐ Enrolled in other Insurance provided by my employer - Carrier name and ID Number _____
- ☐ Enrolled in Individual coverage - Carrier name and ID Number _____
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare
- ☐ Other (Please explain) _____
- ☐ No coverage

9. PRIOR HEALTH INSURANCE INFORMATION *Prior Health Care Coverage During the past 2 years (including Anthem):*

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
	☐ Employee Only ☐ Employee + child(ren) ☐ Employee + spouse ☐ Family		/ /	/ /

10. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No

Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date
			/ /

Policy/Certificate Holder's Name	Social Security Number	Date of birth	Relationship to applicant	Family members covered by Medicare:
		/ /		

Medicare ID #	Part A effective date	Part B effective date	*Medicare eligibility reason (check all that apply)*
			☐ Age ☐ Disability ☐ ESRD: Onset Date _____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date
		/ /	/ /

ANTHEM USE ONLY Coordination of Benefits? ☐ Yes ☐ No Pre-ex (date)

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11. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 5.***

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian*, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide WellPoint with information regarding my HSA. I hereby authorize *the financial custodian* to provide WellPoint with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide WellPoint with a written request to revoke my authorization at any time.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to enrollment. This exclusion may last up to 12 months (9 months in Indiana) from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption.
   I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of creditable coverage from the prior Health Insurance Carrier.
   To obtain a certificate of creditable coverage: 1. Contact the Human Resources area of your prior employer and request a certificate of creditable coverage or other evidence of prior coverage, 2. Contact your prior insurance carrier and request a certificate of creditable coverage or, if necessary, requests the steps to obtain a certificate of creditable coverage, or 3. Contact Anthem at the number on your new identification card for assistance in obtaining a certificate of creditable coverage from your prior insurance carrier. Make sure you provide your current mailing address. Upon receipt of your certificate of creditable coverage, forward a copy to the address on the back of your new identification card.
4. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage).
   However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). 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 dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
   I also understand that my dependents and I may enroll under two additional circumstances:
   - Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
   - My dependent 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.
5. Ohio: If applying for HMO/HIC coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
6. **Ohio:** 3904.04 NOTICE OF INFORMATION PRACTICES: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.
7. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.	In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.	In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 4 above and in Sections 6 through 10 on page 2 are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

By signing Section 5, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. ***Thank you for choosing Anthem Blue Cross and Blue Shield.***