Associations and Trusts Group Enrollment Form

Anthem BlueCross BlueShield

Association/Trust name	Client ID no. (if applicable)
IPEP	

To obtain a proposal:

All groups should complete all **highlighted fields**. Provide additional information based on the underwriting category.

Medically underwritten groups must complete required fields on the front of this form.

Non-medically underwritten groups:

- **Complete** required fields on the front of this form.
- **Employees** applications are **not** required with a request for proposal. All parts of the Employee Application excluding ***Section 3: Medical/Information*** must be completed with a sold case submission.

Section 1: Group Information

Group name			Number of years in business	Medically underwritten ☐ Yes ☐ No
Street address		City	State	ZIP code
Effective date	SIC code	Primary group contact name	Phone no.	Fax no.
Group tax ID no.		Email address		

Section 2: Eligibility

Employees are eligible for health insurance if they work a **minimum of 30 hours per week**.
Important: Every employee working the minimum hours/week must complete an application; those waiving coverage should sign the waiver at end of form.

1. Total number of employees working minimum hours/week
2. Number of employees waiving coverage due to spousal coverage
3. Subtract number 2 from number 1 — Number 1 – number 2 = _____ = Number of eligible employees
4. Number of employees waiving coverage and not covered by spouse
5. Subtract number 4 from number 3 — Number 3 – number 4 = _____ = Number of employees enrolling
6. Divide number 5 by number 1. — Number 5 ÷ number 1 = _____
   This result must be at least 50% otherwise the group is not eligible for coverage under the plan.
7. Divide number 5 by number 3. — Number 5 ÷ number 3 = _____
   This result must be at least 75% otherwise the group is not eligible for coverage under the plan.

The following documents are required with the submission of the confirmed *Group Enrollment Form*:

- Group's Census
- Completed employee enrollment forms
- A copy of the prior carrier's premium billing – **Prior carrier name:** _____

Do employees need to be in subgroups for billing purposes? ☐ Yes ☐ No

Employer medical contribution – If employer pays 100% of premium all eligible employees must enroll.
Employee: _____ % Dependents: _____ %

Probationary period for new employees
The day after: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
First billing date after: ☐ 0 days ☐ 30 days ☐ 60 days
Waive waiting period for current employees? ☐ Yes ☐ No

Return from leave or layoff
Employees returning from a leave of absence or lay off within 63 days will be made effective on the first day of the month following rehire. If more than 63 days has elapsed between date of termination of the group coverage and the rehire date, the probationary or service waiting period will apply.

Employee terminations – Coverage will be terminated the last day of the month.

Section 3: Benefits Requested

Medical				
Plan 1: _____		Plan 2: _____		
Dental	Voluntary	Ortho	Stand-alone	Mixed enrollment
Plan 1: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 2: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 3: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision		Voluntary	Stand-alone	Mixed enrollment
Plan 1: _____		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 2: _____		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 4: Must be completed for 51+ group size — Additional Information for quoting non-medically underwritten groups.

Note: All ASO groups must provide experience regardless of group size.

Broker commission requested: ☐ Standard ☐ Other: _____ PEPM

Please furnish a copy of your last billing statement for medical coverage.

Please answer the following questions to the best of your knowledge for the persons eligible for medical insurance. Include proprietors, partners, employees, spouses and dependent children. Give details to questions answered "Yes" on a separate attachment.

a. Has anyone been treated for a serious illness, been hospitalized or had surgery during the past 12 months? ☐ Yes ☐ No

b. Is anyone expected to have a continuing claim for an existing mental or physical disorder? ☐ Yes ☐ No

c. Has anyone been advised during the last six months to have surgery or does anyone anticipate being hospitalized for an other reason? ☐ Yes ☐ No

d. Is there anyone who, because of illness or injury, is not actively at work or otherwise performing their normal duties on a full-time basis? Employees: ☐ Yes ☐ No Spouses or dependents: ☐ Yes ☐ No

Groups providing experience — The following items are documented for each coverage. Check all that apply and attach supporting documentation.

		Medical	Rx Card
Rate history			
	Renewal	☐	☐
	Current	☐	☐
Shock losses: Over 10k diagnosis/prognosis/status			
	Renewal	☐	☐
	Current	☐	☐
Enrollment history			
	Current	☐	☐
	Previous	☐	☐
Benefit history			
Current description or booklet		☐	☐
Change/date of change		☐	☐
Enrollment by plan		☐	☐

		Medical	Rx Card
Claims experience			
	Current	☐	☐
	Previous	☐	☐
Premium history			
	Current	☐	☐
	Previous	☐	☐
Carrier history			
	Current	☐	☐
	Previous	☐	☐
Current enrollment			
Census (age/sex/tier/product)		☐	☐
COBRA identified		☐	☐
Retirees identified		☐	☐

Section 5: Signatures

Signatures below indicate an understanding that the Plan is being offered based upon information provided to Anthem Blue Cross and Blue Shield. Group rates quoted are valid until the renewal date and will be adjusted, if necessary, based upon the results of the Plan renewal which occurs each year. The group hereby accepts the coverage offered and authorizes Anthem Insurance Companies, Inc. to begin initial set-up.

Group name – typed/printed	Group name signature	Date
	X	

Fraud Notice

Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health 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.

Section 6: Broker certification

Broker name	Agency name (if applicable)	Broker ID no.	Broker phone no.
Public Risk UW of Indiana			800-382-8837

Broker street address	City	State	ZIP code
301 South Reed Road	Kokomo	IN	46903

Broker representative signature	Date
X	

Section 7: Writing agent certification

Agent name	Agency name (if applicable)	Broker ID no.	Broker phone no.

Agency street address	City	State	ZIP code

Anthem sales representative

I certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for a group representative or individual applicant.
4. I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage, or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem reviews and approves the application and the group receives a written notice and contract from Anthem.

Writing agent signature	Date
X	