# Enrollment Application

***Group size 51+ eligible employees***

Please complete in blue or black ink 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 products can be obtained through www.anthem.com

**1. Employer/Group Use:** Employer Name and Address:

| Group # | Sub-group #/Life Division # | Request. Effective Date | Life Classification | Applicant #/Dept. name |
|---|---|---|---|---|
| | | / / | | |

| **Anthem use:** Plan | Health Effective Date | Life Effective Date | Dental Effective Date | Vision Effective Date | PCP | COB | Pre-ex (date) |
|---|---|---|---|---|---|---|---|
| | / / | / / | / / | / / | ☐ Yes ☐ No | ☐ Yes ☐ No | / / |

**2. Reason for Application**

☐ New enrollment
☐ Annual open enrollment (N/A to Life)
☐ COBRA
Qualifying event ______
Event date ___/___/___
☐ Waiver (See Section 11)
☐ New hire
☐ Rehire (date) ___/___/___
☐ Add dependent (see section 3)

**3. Status Change/Event**

Event date ___/___/___
☐ Marriage
☐ Birth
**Include legal documentation.*
☐ Adoption*
☐ Legal Guardianship*
☐ Termed Employment
☐ Other______

**4. Type of Coverage/Plan**

*Health Coverage*
☐ HMO* ☐ POS* ☐ PPO ____
☐ Hospital Surgical
☐ Lumenos® Health Savings Account
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Blue Access℠ Health Savings Account
☐ Blue Access Choice℠ Health Savings Account
☐ Employee only ☐ Employee+spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage
☐ Do you have, or are you establishing a Health Savings Account? ☐ Yes ☐ No
Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

*Dental Coverage*
☐ PPO ____
☐ DentaBlue (PPO)
☐ DentaBlue Select (PPO)
☐ Dental Blue
☐ Dental Blue Choice 100
☐ Dental Blue Choice 300
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage

*Vision Coverage*
☐ Employee Only
☐ Employee + Spouse
☐ Employee + child(ren)
☐ Family Coverage
☐ No coverage

*Life Coverage*
☐ Life (see section 7)

**5. Employee Information** **Only complete Primary Care Physician (PCP) information if enrolling in Medical or Dental HMO or POS.*

| Last name | First name, M.I. | Date of birth | Age | Sex | Social Security # (SS# required for Lumenos® Health Savings Account) | | Height | Weight |
|---|---|---|---|---|---|---|---|---|
| | | / / | | ☐ M ☐ F | - - | ☐ Single ☐ Divorced ☐ Married | | |

| Home address | City | State | Zip code | County |
|---|---|---|---|---|
| | | | | |

| Home telephone | Business telephone | eMail Address |
|---|---|---|
| ( ) | ( ) | |

| *Are you:* Retired? ☐ Yes ☐ No · Disabled? ☐ Yes ☐ No · Hospitalized? ☐ Yes ☐ No | Occupation | Full time hire date | Hours working per week | Income reported by: ☐ W2 ☐ 1099 ☐ Other: ____ |
|---|---|---|---|---|
| | | / / | | |

| Anthem PCP name and address* | Anthem PCP ID number* | New patient?* ☐ Yes ☐ No |
|---|---|---|

**6. Family Information** **Spouse and dependents to be covered (Attach a separate sheet if necessary)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

| 1 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other____ | Fulltime student? ☐ Yes ☐ No |
|---|---|---|---|

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

| Date of birth | Sex | Social Security # | Height | Weight | |
|---|---|---|---|---|---|
| / / | ☐ M ☐ F | - - | | | Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation)<br>Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason) |

| Anthem PCP name and address* | Anthem PCP ID number* | New patient?* ☐ Yes ☐ No |
|---|---|---|

| 2 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other____ | Fulltime student? ☐ Yes ☐ No |
|---|---|---|---|

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

| Date of birth | Sex | Social Security # | Height | Weight | |
|---|---|---|---|---|---|
| / / | ☐ M ☐ F | - - | | | Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation)<br>Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason) |

| Anthem PCP name and address* | Anthem PCP ID number* | New patient?* ☐ Yes ☐ No |
|---|---|---|

| 3 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other____ | Fulltime student? ☐ Yes ☐ No |
|---|---|---|---|

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

| Date of birth | Sex | Social Security # | Height | Weight | |
|---|---|---|---|---|---|
| / / | ☐ M ☐ F | - - | | | Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation)<br>Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason) |

| Anthem PCP name and address* | Anthem PCP ID number* | New patient?* ☐ Yes ☐ No |
|---|---|---|

### 7. 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* | | | - - | | |

### 8. Other Health Coverage *Please check one:* ☐ *YES (completed below.)* ☐ *NO*

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 number | Effective date |
|---|---|---|
| | | / / |

| Policy/certificate holder's name | Social Security number | Date of birth | Relationship to applicant |
|---|---|---|---|
| | – – | / / | |

**If you and/or your dependents are enrolled in Medicare, complete the following.**

| Enrollee's name(s) | Medicare ID# | Medicare Part A effective date | Medicare Part B effective date | ESRD onset date |
|---|---|---|---|---|
| | | / / | / / | / / |
| | | / / | / / | / / |
| **Medicare Part D ID#** | **Medicare Part D Carrier** | **Medicare Part D effective date** | **Medicare Part D term date** | |
| | | / / | / / | |

Reason for Medicare entitlement:
☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

### 9. Prior Health Coverage *Please check one:* ☐ *YES (completed below.)* ☐ *NO*

| Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No<br>Policy/Certificate #: | Group name/ID# | Date policy in effect:<br>/ / — / / |
|---|---|---|
| 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) | Dates Policy in effect:<br>/ / — / / |

Please check the type of prior coverage
☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased
☐ Other:

## Significant Terms, Conditions and Authorizations (TERMS)

*Please read this section carefully before signing the application.*

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.

2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.

3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.

4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company, which underwrites only life and disability coverages, may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Unless I applied for HMO/POS coverage, in which case there is no such exclusion.)

5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.

6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

   I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by one of the following companies:

Healthy Alliance Life Insurance Company for PPO, HMO Missouri, Inc. for HMO, and for POS both Healthy Alliance Life Insurance Company and HMO Missouri, Inc.

***Thank you for choosing Anthem Blue Cross and Blue Shield***

**10. Read the TERMS section on page 3 carefully before signing. Please review your application for errors or omissions.**

By signing this, 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.

| Applicant Signature | Date / / |
|---|---|

**11. Waiver of coverage for employee and / or any eligible dependent not enrolling**

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

| Name of person waiving | | Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None |
|---|---|---|
| Employer name | Carrier: ☐ Anthem (give certificate/policy #) | ☐ Other carrier (give name, ID #) |

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

| Name of person waiving | | Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None |
|---|---|---|
| Employer name | Carrier: ☐ Anthem (give certificate/policy #) | ☐ Other carrier (give name, ID #) |

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

| Name of person waiving | | Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None |
|---|---|---|
| Employer name | Carrier: ☐ Anthem (give certificate/policy #) | ☐ Other carrier (give name, ID #) |

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

| Name of person waiving | | Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None |
|---|---|---|
| Employer name | Carrier: ☐ Anthem (give certificate/policy #) | ☐ Other carrier (give name, ID #) |

**Check all that apply**

☐ I represent that 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. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) 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. 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 represent that 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. Neither my dependent(s) nor I were 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 such coverage in the future, I may be required to provide evidence of insurability at my expense.

| Applicant Signature | Date / / |
|---|---|