

Employee Enrollment Application



Your Anthem enrollment application is inside.

It is essential that you read it carefully and complete all the necessary sections.

If you are a new enrollee:

- a) applying for health, vision and/or dental benefits, please complete sections 2, 4, 5, 6, 7, 8, and 9. Your signature is required in Section 9.
- b) waiving any or all benefits, please complete sections 2, 5 and 10. Your signature is required in Section 10.

If you are adding a dependent(s),
complete section 3 in addition to the above.

It is important that you read and understand the Significant Terms, Conditions and Authorizations in Section 9.

***Thanks for choosing Anthem
Blue Cross and Blue Shield.***

Note: You may be required to supply additional information.

www.anthem.com

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Administered by Anthem Blue Cross and Blue Field.
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.
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Enrollment Application



Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Please complete in 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 Use: Employer Name and Address:						
Group #	Sub-group #	Request. Effective Date	Applicant #/Dept. name			
		/ /				
Anthem use: Plan	Health Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

2. Reason for Application		4. Type of Coverage/Plan		
<input type="checkbox"/> New enrollment <input type="checkbox"/> Waiver <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Conversion Qualifying event _____ Event date ____/____/____		<input type="checkbox"/> New hire <input type="checkbox"/> Rehire (date) ____/____/____ <input type="checkbox"/> Add dependent (see section 3) <input type="checkbox"/> Other _____		
3. Status Change/Event		Health Coverage		
Event date ____/____/____ <input type="checkbox"/> Marriage <input type="checkbox"/> Birth *Include legal documentation.		<input type="checkbox"/> HMO* (not applicable to Ohio) <input type="checkbox"/> Blue Traditional® <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> EPO (Ohio only)		
<input type="checkbox"/> Adoption* <input type="checkbox"/> Legal guardianship* <input type="checkbox"/> Other _____		Dental Coverage		
		<input type="checkbox"/> PPO <input type="checkbox"/> Traditional (Indiana and Ohio only)		
		Vision Coverage		
		<input type="checkbox"/> Vision <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage		

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

Last name	First name, M.I.	Date of birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married
Home address	City	State	Zip code	County (KY residents include Municipality)		
Home telephone () -	Business telephone () -	eMail Address				
Are you: 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	Full time hire date	Hours working per week	Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____		
Anthem PCP name and address*		Anthem PCP ID number*		New patient?*		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		

6. Family Information Spouse and dependents to be enrolled. (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	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)	
Anthem PCP name and address*		Anthem PCP ID number*		New patient?*
				<input type="checkbox"/> Yes <input type="checkbox"/> No
2 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)	
Anthem PCP name and address*		Anthem PCP ID number*		New patient?*
				<input type="checkbox"/> Yes <input type="checkbox"/> No
3 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)	
Anthem PCP name and address*		Anthem PCP ID number*		New patient?*
				<input type="checkbox"/> Yes <input type="checkbox"/> No
4 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)	
Anthem PCP name and address*		Anthem PCP ID number*		New patient?*
				<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Other Health Coverage Please check one: <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> 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 or Medicaid, complete the following.				
Enrollee's name(s)	Medicare / Medicaid 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: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD & Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)				

8. Prior Health Coverage Please check one: <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> NO	
Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates policy in effect: / / — / /
Policy/Certificate #:	
Have you and / or your dependents had prior coverage with another carrier(s) within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates policy in effect: / / — / /
Please check the type of prior coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)	
Termination reason: <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of spouse <input type="checkbox"/> COBRA coverage exhausted <input type="checkbox"/> Employment terminated <input type="checkbox"/> Group plan terminated <input type="checkbox"/> Employer/group contribution ceased <input type="checkbox"/> Other:	

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
- I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
- I am applying for the benefit 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.
- I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application 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.
- I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
- 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 enrollment. 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 benefits or rates. Any material misrepresentation

or significant omission found in this application may result in denial of benefits or rescission or cancellation of my benefits.

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.

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 benefit plan will be administered by one of the following companies based upon the state in which your employer 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.

Thank you for choosing Anthem Blue Cross and Blue Shield.

9. Read the TERMS section above 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 / /

Please complete the waiver on the next page if you and / or any eligible dependent are not enrolling.

10. Waiver of coverage for employee and / or any eligible dependent not enrolling		
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All		
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #)	<input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All		
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #)	<input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All		
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #)	<input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All		
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #)	<input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All		
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #)	<input type="checkbox"/> Other carrier (give name, ID #)
<p>I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures.</p> <p>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 benefit booklet, 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.</p>		
Applicant Signature	Date / /	