

# Enrollment Application



Group size 20-50 eligible employees

Please complete in 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 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 MEDICAL COVERAGE REQUESTED:		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage					
2. ENROLLMENT INFORMATION							
Relationship	Last Name, First Name, M.I.	Social Security no.	Sex	Claimed on Taxes?	Age	Date of birth	Height/Weight
Employee			<input type="checkbox"/> M <input type="checkbox"/> F				/
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F				/
<input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N			/
<input type="checkbox"/> Son <input type="checkbox"/> Daughter Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N			/
Employee Home Address: Street, City, State, ZIP Code						County	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married
Employee Home Phone (    )	Employee Work Phone (    )	Employee Email Address		Employer			
<b>Note:</b> If your dependent does not reside with you, or is 19 years or older, please list their name and address on a separate sheet of paper. For dependents under court-ordered coverage or for those hospitalized or disabled, please provide appropriate legal documentation.							
3. MEDICAL INFORMATION							
1. Current medication?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient name	Medication name	Medical condition	Dates taken			
	Patient name	Medication name	Medical condition	Dates taken			
	Patient name	Medication name	Medical condition	Dates taken			
2. Treatment, surgery, or testing discussed or advised but not yet done (including pregnancy)?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient name	Date/Due Date	Details				
	Patient name	Date/Due Date	Details				
3. Visited a doctor, been hospitalized, or had any testing, medical or surgical treatments in the past 24 months?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient name	Date	Purpose of visit, hospitalization, or treatment				
	Patient name	Date	Purpose of visit, hospitalization, or treatment				
	Patient name	Date	Purpose of visit, hospitalization, or treatment				
SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS)							
<p><b>Please read this section carefully before signing the application.</b></p> <p>I acknowledge I have read the TERMS, and I accept its provisions as condition of coverage. I represent that all answers to questions on this application are true and accurate to the best of my knowledge and I understand they will be relied on by Anthem 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 benefits denied or coverage(s) rescinded or cancelled.</p> <p><b>Ohio:</b> 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.</p> <p><b>Kentucky:</b> 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.</p>							
<b>READ THE TERMS SECTION ABOVE CAREFULLY BEFORE SIGNING. PLEASE REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.</b>							
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. 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.							
Applicant signature 		Please Print Name			Date		

# Enrollment Application

Group size 20-50 eligible employees



Please complete in ink and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

<b>4. COVERAGE SELECTION</b> <i>(Availability dependent upon your employer's offering)</i>			<b>5. WAIVER OF COVERAGE SECTION:</b> <i>(Must be completed if employee and/or dependents waive medical, dental or life coverage)</i>				
Medical benefits: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other _____ <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage	Dental benefits: <input type="checkbox"/> PPO <input type="checkbox"/> Traditional <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage	Other coverage: <input type="checkbox"/> Life/AD&D <input type="checkbox"/> STD <input type="checkbox"/> Dependent Life <input type="checkbox"/> LTD <input type="checkbox"/> Supp. Life <input type="checkbox"/> Supp. AD&D	Name of person waiving _____ Type of Coverage Waiving: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		Already covered by: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other _____		Carrier _____
<b>1. If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at <a href="http://www.anthem.com">www.anthem.com</a>.</b> <b>2. A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.</b>			Name of person waiving _____ Type of Coverage Waiving: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life		Already covered by: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other _____		Carrier _____
Primary Beneficiary for Life Coverage: Name _____ Relationship _____		Contingent Beneficiary: Name _____ Relationship _____					
<b>6. OTHER HEALTH INSURANCE INFORMATION</b>							
<i>Prior Health Care Coverage During the past 2 years (including Anthem):</i>							
Insurance company name(s): _____		Type of prior coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee/child(ren) <input type="checkbox"/> Employee/spouse <input type="checkbox"/> Employee/spouse/child(ren)		Policy number _____	Effective Date _____	Cancel Date _____	
<i>On the day your coverage begins, list family members, including yourself, who will be covered by other health insurance coverage and/or Medicare or Medicaid</i>							
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/Medicaid ID # _____	Part A effective date _____	Part B effective date _____	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset Date _____			
Family members covered by Medicare: _____	Medicare/Medicaid ID # _____	Part A effective date _____	Part B effective date _____	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset Date _____			
<b>SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS): Please read this section carefully before signing the application.</b>							
1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program. 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. 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. 4. <b>Ohio:</b> 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. 5. <b>Ohio: 3904.04 NOTICE OF INFORMATION PRACTICES:</b> I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may and 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. 6. 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.			
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. 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. <b>Thank you for choosing Anthem Blue Cross and Blue Shield.</b>							
Applicant signature _____ 			Please Print Name _____			Date _____	
<b>ANTHEM USE ONLY</b>	<b>7. TO BE COMPLETED BY EMPLOYER</b>		Group Name _____		Group Number _____	Sub Group Number _____	
Coordination of Benefits <input type="checkbox"/> Yes  <input type="checkbox"/> No	Reason for application: <input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment (n/a for Life) <input type="checkbox"/> Add dependent Event _____ Event Date _____ <input type="checkbox"/> COBRA (reason/date) _____ <input type="checkbox"/> Waiver		Group Address _____		Employee Hire/Rehire date (Full time) _____		
Pre-ex (date) _____			Employee status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	Hours Working per Week _____  If not actively working, reason _____  Projected Return Date _____	Occupation _____  Annual Salary _____  Life Class _____	Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other _____	