

# 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](http://www.anthem.com).

<b>1. Employer Use:</b> Employer Name and Address:							
Group #	Sub-group #	Request. Effective Date / /		Applicant #/Dept. name			
<b>Anthem use:</b> Plan	Health Effective Date / /	Dental Effective Date / /	Vision Effective Date / /	PCP <input type="checkbox"/> Yes <input type="checkbox"/> No	COB <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-ex (date) / /	
<b>2. Reason for Application</b>				<b>3. Status Change/Event</b>			
<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)		Event date ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Birth *Include legal documentation.		<input type="checkbox"/> Adoption* <input type="checkbox"/> Legal guardianship* <input type="checkbox"/> Other _____	
<b>4. Type of Coverage/Plan</b>							
<i>Health Coverage</i> Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.			<i>Dental Coverage</i>		<i>Vision Coverage</i>		
<input type="checkbox"/> HMO* (not applicable to Ohio) <input type="checkbox"/> Anthem Essential <sup>SM</sup> PPO <input type="checkbox"/> Anthem Essential <sup>SM</sup> Choice PPO <input type="checkbox"/> Blue Traditional <sup>®</sup> <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> EPO (Ohio only) <input type="checkbox"/> Blue Access <sup>SM</sup> Hospital Surgical PPO (IN, KY, OH only) <input type="checkbox"/> Blue Access <sup>SM</sup> Hospital Surgical PPO (MO only) <input type="checkbox"/> Blue Access <sup>SM</sup> Choice Hospital Surgical PPO (MO only) <input type="checkbox"/> Blue Preferred <sup>®</sup> Plus Hospital Surgical POS (WI only) <input type="checkbox"/> Blue Preferred <sup>®</sup> ASO/EPO <input type="checkbox"/> Lumenos <sup>®</sup> Health Savings Account			<input type="checkbox"/> PPO <input type="checkbox"/> Traditional (Indiana and Ohio only) <input type="checkbox"/> Dental Blue <sup>®</sup> <input type="checkbox"/> Dental Blue <sup>®</sup> Choice 100 <input type="checkbox"/> Dental Blue <sup>®</sup> Choice 300 <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		<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		
<b>5. Employee Information</b> *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	
Home address			City	State	Zip code	Social Security # (required) - - - - - <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	
Home telephone ( ) -		Business telephone ( ) -		eMail Address			
Are you: <input type="checkbox"/> Yes <input type="checkbox"/> No	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	
Anthem PCP name and address*				Anthem PCP ID number*		New patient?*	
*Please read the Genetic Information Non-discrimination Act (GINA) information on page 3, under Significant Terms, Conditions and Authorizations section, prior to answering the below questions.							
1 Last name		First name, M.I.		Relationship <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 # (required for spouse/domestic partner) - - - - -		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?*	
2 Last name First name, M.I. Relationship <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?*	

3 Last name		First name, M.I.		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son to applicant <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 <input type="checkbox"/> Spouse <input type="checkbox"/> Son to applicant <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	
<b>7. Other Health Coverage</b> <i>Please check one:</i> <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		
<b>If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.</b>								
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)								
<b>8. Prior Health Coverage</b> <i>Please check one:</i> <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> NO								
Have you been covered by Anthem within the past two (2) years? Policy/Certificate #:			<input type="checkbox"/> Yes <input type="checkbox"/> No		Group name/ID#	Dates Policy in effect: / / - / /		
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					List prior carrier(s)	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)**

**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.

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

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. 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.
4. 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.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
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 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.

NAME \_\_\_\_\_

SSN \_\_\_\_\_

**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.

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 Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI") administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") administers the HMO and POS policies.

**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 / /

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

Check all that apply. Waiving:  Health  Dental  Vision  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  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  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  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  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 #)

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.

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. 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.

Applicant Signature \_\_\_\_\_ Date / /