

Enrollment Application



Group size 2-19 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: Employee Only Employee + Spouse Employee + Child(ren) Family 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 Single
 Divorced
 Married

Employee Home Phone () () Employee Work Phone () () Employee Email Address Employer

Note: 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

(If yes, circle condition)

1. Do you or your dependents regularly take medication? Yes No

2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? Yes No

3. Are you or any of your dependents currently pregnant? Yes No
If yes, name _____ due date ____ / ____ / ____

4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes (list age of onset below); mental/nervous disorder; depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? Yes No

5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? Yes No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				

SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS)

Please read this section carefully before signing the application.

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.

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.

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. 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

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4. COVERAGE SELECTION (Availability dependent upon your employer's offering)				5. WAIVER OF COVERAGE SECTION: (Must be completed if employee and/or dependents waive medical, dental or life coverage)			
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		Name of person waiving _____ Type of Coverage Waiving: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	
1. If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com . 2. A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.				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 _____		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 _____	
Applicant signature for waiver 				Date _____			
6. OTHER HEALTH INSURANCE INFORMATION							
Prior Health Care Coverage During the past 2 years (including Anthem):							
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 _____
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							
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 _____			
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 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. Ohio: 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. Ohio: 3904.04 NOTICE OF INFORMATION PRACTICES: 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. Thank you for choosing Anthem Blue Cross and Blue Shield.							
Applicant signature 			Please Print Name _____			Date _____	
ANTHEM USE ONLY	7. TO BE COMPLETED BY EMPLOYER		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 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 _____	
Pre-ex (date) _____					Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other _____		