

# Enrollment Application

## Group size 2-50 eligible employees



Please complete in black or blue 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. 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.

### Section 1: Type of coverage requested

Employee only  
  Employee + spouse  
  Employee + child(ren)  
  Family  
  Life only  
  No coverage

### Section 2: Enrollment information

Single  
  Married  
  Divorced

Relationship	Last name, first name, M.I.	Social Security no. required*	Sex	Age	Date of birth (MM/DD/YY)	Height	Weight	Current tobacco user	Disabled
Employee			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other: _____			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other: _____			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other: _____			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee home street address		City		State	ZIP code	County			
Employee home phone		Employee work phone		Employee email address					
Dependent home street address – if different from employee		City		State	ZIP code	Dependent names			

### Section 3: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.

- Do you or your dependents regularly take medication? .....  Yes  No
- Has a physician told you or any of your dependents that surgery or special tests (excluding AIDS and HIV) or treatment may be necessary in the future? .....  Yes  No
- Are you or any of your dependents currently pregnant? .....  Yes  No  
If yes, name: \_\_\_\_\_ Due date: \_\_\_\_\_ (MM/DD/YYYY)
- In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? .....  Yes  No
- In the last 5 years have you or any of your dependents been diagnosed or treated for any of the following?  Yes  No Check all that apply.
 

<input type="checkbox"/> Heart/circulatory condition	<input type="checkbox"/> Cancer/tumor	<input type="checkbox"/> Disorder of the blood or immune system (excluding AIDS and HIV)
<input type="checkbox"/> Stroke, aneurysm	<input type="checkbox"/> Diabetes (list age of onset below)	<input type="checkbox"/> Mental/nervous disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney, liver or pancreas disorder	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Lupus	<input type="checkbox"/> Lung disorder	<input type="checkbox"/> COPD
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back/disk disorder	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Other condition: _____		<input type="checkbox"/> Alcohol or drug abuse/dependency
		<input type="checkbox"/> Crohn's disease
		<input type="checkbox"/> Emphysema
		<input type="checkbox"/> Muscular dystrophy

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

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date	Date(s) of treatment	Hospitalized	Surgery	Recovered
					/ /	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					/ /	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					/ /	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					/ /	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

\*Anthem is required by the Internal Revenue Service to collect this information.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Life and Disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association.

ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

**Section 4: Life and disability insurance**

<input type="checkbox"/> Basic Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> Optional Life: _____ x annual earnings OR \$ _____ <input type="checkbox"/> Current income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		<input type="checkbox"/> Basic AD&D <input type="checkbox"/> Optional AD&D		<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability		<input type="checkbox"/> Anthem by Design® Short Term Disability BUY-UP <input type="checkbox"/> Anthem by Design® Long Term Disability BUY-UP <input type="checkbox"/> Anthem by Design® Basic Life BUY-UP Complete separate election form.		Life class
Primary beneficiary	Last name	First name	M.I.	Social Security no.	Relationship to applicant	Age		
Contingent beneficiary	Last name	First name	M.I.	Social Security no.	Relationship to applicant	Age		

**Section 5: Reason for application**

<input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment (N/A for Life coverage) <input type="checkbox"/> COBRA Event: _____ Date: _____ <input type="checkbox"/> State Continuation <input type="checkbox"/> Waiver	Qualifying event— please complete date and reason. Event date: _____ <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption <input type="checkbox"/> Terminated employment <input type="checkbox"/> Other: _____
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**Section 6: Group information**

Group name		Group no.		Subgroup no.	
Group street address		City		State	ZIP code
Employee status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other: _____		Hours working per week	Occupation		If not actively at work, reason
Projected return date	Annual salary	Income reported by <input type="checkbox"/> W-2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____			

**Section 7: Coverage selection – Availability dependent upon your employer’s offering**

**Medical coverage – Select one:**  Employee only  Employee + spouse  Employee + child(ren)  Family  No coverage

**Check the medical plan you are applying for:**

<input type="checkbox"/> PPO	<input type="checkbox"/> Traditional	<input type="checkbox"/> HDHP/PPO	<input type="checkbox"/> PPO/PPO	<input type="checkbox"/> Lumenos® Health Savings Account*
<input type="checkbox"/> Anthem Essential <sup>SM</sup> PPO	<input type="checkbox"/> Blue Access® Hospital Surgical PPO	<input type="checkbox"/> Core	<input type="checkbox"/> Core	<input type="checkbox"/> Lumenos® Health Reimbursement Account*
<input type="checkbox"/> HMO (HIC in Ohio)	<input type="checkbox"/> HDHP	<input type="checkbox"/> Buy Up	<input type="checkbox"/> Buy Up	<input type="checkbox"/> Lumenos® Health Incentive Account*
<input type="checkbox"/> POS (Ohio only)				<input type="checkbox"/> Lumenos® Health Incentive Account Plus*

\*Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

**Dental coverage – Select one:**  Employee only  Employee + spouse  Employee + child(ren)  Family  No coverage

**Vision coverage – Select one:**  Employee only  Employee + spouse  Employee + child(ren)  Family  No coverage

If enrolling in an HMO product, please submit a PCP selection form. Anthem’s PCP listings can be obtained at anthem.com.  
 A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.

**Section 8: Waiver of coverage – Must be completed if employee and/or dependents waive medical, vision, dental or life coverage.**

**NOTE: If waiving coverage, please complete this section. Section 12 must also be signed and dated.**

<b>Medical coverage declined for – Check all that apply:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <b>Dental coverage declined for – Check all that apply:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <b>Vision coverage declined for – Check all that apply:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <b>Life coverage declined for:</b> <input type="checkbox"/> Myself	<b>Reason for declining coverage – Check all that apply:</b> <input type="checkbox"/> Covered by spouse’s group coverage Carrier name: _____ ID no.: _____ <input type="checkbox"/> Enrolled in other Insurance provided by my employer Carrier name: _____ ID no.: _____ <input type="checkbox"/> Enrolled in Individual coverage Carrier name: _____ ID no.: _____ <input type="checkbox"/> Spouse covered by employer’s group medical Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Other: _____ <input type="checkbox"/> No coverage
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**Section 9: Prior health insurance information – Prior health care coverage during the past two years (including Anthem)**

Insurance company name(s)	Policy no.	Effective date	Cancellation date
Type of prior coverage: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family			

**Section 10: Other health insurance information**

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Family members covered by other health coverage				
Insurance company name			Policy no.	Effective date
Insurance company street address		City	State	ZIP code
Insurance company phone no.				
Policy/certificate holder's name		Social Security no.	Date of birth	Relationship to applicant
Family members covered by Medicare				Medicare ID no.
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"/> ERSD – Onset date: _____		
Medicare Part D carrier		Medicare Part D ID no.	Part D effective date	Part D termination date
<b>ANTHEM USE ONLY –</b> Coordination of benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**Section 11: Significant Terms, Conditions and Authorizations (TERMS) please read this section carefully before signing the application in section 12.**

**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 myHealth Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross BlueShield with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

**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.

1. I may not assign any payment under my Community Insurance Company (Anthem) program unless required by law.
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).
3. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). 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 dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for 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.

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 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.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon 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 increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

**W-9 Certification Language**

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

**Section 12: Signature required**

By signing below, 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 Anthem.

Applicant signature <b>X</b>	Printed name	Date
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Thank you for choosing Anthem Blue Cross and Blue Shield.