Employee Enrollment Application For 1-50 Employee Small Groups Ohio

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in black ink only.

Section A: Employee Information					
Last name	First name		M.I.	Social Security no.* (required)	
Home address - Street and PO Box if applicable					
City	County		State	ZIP code	
Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.		Secondary phone no.		
Employee email address					
Employer name			Group no. (if known)		
Employer street address					
City			State	ZIP code	
Employment status ☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired	Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week	

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Section B: Application Type			
Select one			
☐ New enrollment ☐ Open enrollment (not applicable for Life and Disability) ☐ Rehire - Rehire Date _____	☐ COBRA - **Select qualifying event** ☐ Left employment ☐ Loss of dependent child status ☐ Covered employee's Medicare entitlement ☐ Involuntary loss of coverage	☐ Medicare ☐ Reduction in hours ☐ Divorce or legal separation ☐ Death	Qualifying event date: ____/____/_____ (MM/DD/YYYY)

Section C: Type of Coverage

1. Medical Coverage – Check all that apply.

PPO Plans	Anthem Gold	Anthem Silver	Anthem Bronze
Blue Access	☐ 500/20%/4000 ☐ 1000/20%/3750 ☐ 1350C/0%/3000 w/ HSA ☐ 1500/10%/2900 w/HSA ☐ 1500/20%/4000 ☐ 1750/0%/3425 w/HSA ☐ 2000/0%/2500 Plus w/HSA ☐ 2000/20%/4000 ☐ 2250/0%/2750 Plus w/HSA ☐ 2500/0%/7350 ☐ 2800/0%/3800	☐ 2500/50%/7000 ☐ 2700E/20%/4500 w/HSA ☐ 2700EC/0%/4800 w/HSA ☐ 3000EC/0%/4000 w/HSA ☐ 3500/30%/7350 ☐ 3500E/0%/5500 Plus w/HSA ☐ 4200E/0%/5500 Plus w/HSA ☐ 4500/30%/7350 ☐ 4900E/0%/6000 Plus w/HSA ☐ 5000/20%/7100 ☐ 6000/0%/6850 ☐ 6300/20%/7350	☐ 3500E/50%/6550 w/HSA ☐ 5000E/10%/6550 w/HSA ☐ 5500EC/0%/6550 w/HSA ☐ 6000EC/20%/6550 w/HSA ☐ 6250E/0%/6550 Plus w/HSA ☐ 6550E/0%/6650 Plus w/HSA ☐ 6600/50%/7350
HMO Plans	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
Pathway Group	☐ 500/20%/4000 ☐ 1000/20%/3750 ☐ 1350C/0%/3000 w/ HSA ☐ 1750/0%/3425 w/HSA ☐ 2000/20%/4000 ☐ 2500/0%/7350	☐ 2500/50%/7000 ☐ 2700EC/0%/4800 w/HSA ☐ 3500E/0%/5500 w/HSA ☐ 4200E/0%/5500 w/HSA ☐ 4900E/0%/6000 w/HSA ☐ 6000/0%/6850	☐ 5000E/10%/6550 w/HSA ☐ 5500EC/0%/6550 w/HSA ☐ 6250E/0%/6550 w/HSA ☐ 6600/50%/7350

☐ Other_____

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code - Please indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.

Contract code: _____

2. Dental Coverage - Please ask your employer which dental options are available before checking your selection.

Anthem Dental Family and Anthem Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and , Anthem Dental Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Member dental coverage - select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code - Please indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Contract code: _____

3. Vision Coverage - select one plan option.

Member vision coverage - select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code - Please indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Contract code: _____

4. Life and Disability Coverage - A minimum of two employees must enroll.	
☐ Basic Life and AD&D ☐ Basic Dependent Life ☐ Optional Supplemental/Voluntary Life and AD&D $ _____ (employee amount) ☐ Optional Supplemental/Voluntary Dependent Life Spouse $ _____ (spouse amount) ☐ Optional Supplemental/Voluntary Dependent Life Child $ _____ (child amount)	☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability

Current annual income: $ _____	Occupation	Life and Disability class no.

Primary Beneficiary - Attach a separate sheet if necessary.					
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Contingent Beneficiary					
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

Spousal Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a Spouse's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your Spouse/Domestic Partner if your Spouse/Domestic Partner will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse/ Domestic Partner read and sign the following. I am aware that my Spouse/Domestic Partner, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature	Spouse name	Date (MM/DD/YYYY)
X		/ /

Section D: Coverage Information - All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your Spouse/domestic partner, your children, or your Spouse's/Domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Employee last name			First name	M.I.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate(MM/DD/YYYY)	Relationship to applicant Self	
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? Are you currently enrolled or willing to enroll in a tobacco cessation wellness program?				☐ Yes ☐ No ☐ Yes ☐ No
Primary Care Physician (PCP) name			PCP ID no.	Existing patient ☐ Yes ☐ No

Spouse/Domestic Partner last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate(MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner		
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? Is this person currently enrolled or willing to enroll in a tobacco cessation wellness program?					☐ Yes ☐ No ☐ Yes ☐ No
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate(MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?______________		
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program?					☐ Yes ☐ No ☐ Yes ☐ No
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐Yes ☐No If yes, please enter: ____					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate(MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?______________		
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program?					☐ Yes ☐ No ☐ Yes ☐ No
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐Yes ☐No If yes, please enter: ____					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate(MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?______________		
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program?					☐ Yes ☐ No ☐ Yes ☐ No
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐Yes ☐No If yes, please enter: ____					

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Section E: Prior & Other Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No
If yes, give name:__________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason(check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date ____________________

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY)

On the day your coverage begins, will you or a family member be covered by Medicare? ☐ Yes ☐ No
On the day your coverage begins, will you or a family member be covered by other health coverage? ☐ Yes ☐ No
On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following. If any coverage will remain in force once you enroll with Anthem, leave the End date blank.

Name of person covered (Last name, first, M.I.)	**Type (Check one)**	**Coverage (check all that apply)**	**Carrier name**	**Carrier phone no.**	**Policy ID no.**	**Dates (if applicable) (MM/DD/YYYY)**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**

Section F: Waiver/Declining Coverage	
Medical coverage declined for - check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for - check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for - check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
***Life/AD&D** coverage declined for:	☐ Myself
Spouse, Domestic Partner and Dependent coverage not available if life coverage is waived/declined.	
Dependent Life coverage declined for:	☐ Spouse/Domestic Partner and Dependents
Short Term Disability coverage declined for:	☐ Myself
Long Term Disability coverage declined for:	☐ Myself
Optional Supplemental/Voluntary coverage declined for:	☐ Myself
Optional Supplemental/Voluntary Dependent Life coverage declined for:	☐ Spouse/Domestic Partner and Dependents
Voluntary Short Term Disability coverage declined for:	☐ Myself
Voluntary Long Term Disability coverage declined for:	☐ Myself
Reason for declining coverage - check all that apply:	☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Enrolled in other Insurance - Please provide company name and plan:_____ ☐ Enrolled in Individual coverage ☐ Spouse/Domestic Partner covered by employer's group medical Coverage ☐ Medicare/Medicaid/VA ☐ Other - please explain: _____ ☐ No coverage

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant **X**	Printed name	Today's Date (MM/DD/YYYY)

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem Blue Cross and Blue Shield (Anthem) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's Spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. Any person who, with intent to defraud or knowing that he 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. I understand all benefits are subject to conditions stated in the Group Agreement and coverage document.

In signing this application I represent that:

- I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I certify each Social Security number listed on this application is correct.
- I understand that I may not assign any payment under my Anthem program. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
- I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
- I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.
- I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).
- I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

For Health Savings Account enrollees: 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 Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

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.

Life and/or Disability Authorization Section – Read carefully before signing.

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem. This information will be used for purposes which mean: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that 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 this law by writing to Anthem.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic partner unless he/she signs below. I am acting as their agent and representative.

Fraud Notice

Any person who, with intent to defraud or knowing that he 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.

Sign here	Signature of applicant* or legal representative X	Date (MM/DD/YYYY)
	Signature of spouse/domestic partner X	Date (MM/DD/YYYY)

*(or Custodial Parent's or Guardian's signature if applicant is under age 18)

Special Enrollment Rights for Medical Coverage Only

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you 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 your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.