Enrollment Application

Anthem | Anthem Life

Group size 2-99 eligible employees

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.

KS Residents only: Coverage applied for: ☐ PPO/Traditional (Healthy Alliance Life Insurance Company) ☐ Life & Disability (Anthem Life Insurance Company)

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. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or 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 COVERAGE REQUESTED: ☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family ☐ Life Only ☐ No coverage

2. ENROLLMENT INFORMATION ☐ **Single** ☐ **Divorced** ☐ **Married**

Relationship	Last Name, First Name, M.I.	Social Security No. Required	Sex	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No

Employee Home Address: Street, City, State, ZIP Code | County

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

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) | Dependent Name(s)

3. MEDICAL INFORMATION ***(If yes, circle condition)***

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

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/growth; disorder of the blood or immune system; stroke, aneurysm, high blood pressure, diabetes **(list age of onset below)**; mental/nervous disorder; Parkinson's disease; migraine/cluster headaches; seizures/epilepsy; depression; alcohol or drug abuse/dependency; kidney disease; kidney stones; liver or pancreas disorder; digestive/intestinal disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; muscular dystrophy; infertility/reproductive organ disorder; congenital disease or birth defect; cerebral palsy; or any other condition? ☐ 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	Onset Date	Date(s) of Treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. 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 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 Blue Cross and Blue Shield 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.

READ THE TERMS SECTIONS 4 AND 11 CAREFULLY BEFORE SIGNING. PLEASE REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant Signature | Please Print Name | Date / /

ANTHEM USE ONLY

Coordination of Benefits? ☐ Yes ☐ No | Pre-ex (date)

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5. PLEASE COMPLETE ALL INFORMATION

Reason for application:
- ☐ New enrollment
- ☐ Open enrollment (N/A for Life coverage)
- ☐ Qualifying event (please complete date and reason)
  Event Date ____/____/____
  - ☐ Marriage ☐ Divorce
  - ☐ Birth of Child ☐ Adoption
  - ☐ Termed Employment
  - ☐ Other
- ☐ COBRA
  Event _____
  Date ____/____/____
- ☐ State Continuation ☐ Waiver

Group Name	Group number	Sub Group Number

Group Address	Employee Hire/Rehire Date (Full time)
	/ /

Employee status	Hours working per Week	Occupation	Income reported by:
☐ Active ☐ Disabled ☐ Retired ☐ Other (please explain)	_____ If not actively working, reason Projected Return Date ____/____/____		☐ W2 ☐ 1099 ☐ Other (please explain)

6. COVERAGE SELECTION *(Availability dependent upon your employer's offering)*

Medical Coverage
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Check the medical plan you are applying for:
- ☐ PPO
- ☐ Blue Preferred® Select
- ☐ Anthem Essential℠ PPO
- ☐ Anthem Essential℠ Choice PPO
- ☐ Anthem Essential℠ Select
- ☐ HMO
- ☐ POS
- ☐ Hospital Surgical
- ☐ HDHP*
- ☐ HDHP*/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ PPO/PPO
  - ☐ Core
  - ☐ Buy Up

- ☐ Lumenos® Health Savings Account
- ☐ Lumenos® Health Reimbursement Account
- ☐ Lumenos® Health Incentive Account
- ☐ Lumenos® Health Incentive Account Plus
- ☐ Blue Access® Health Savings Account
- ☐ Blue Access® Choice Health Savings Account

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

*Do you have, or are you establishing a Health Savings Account?
☐ Yes ☐ No

Dental Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Vision Coverage:
Please check one type:
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + child(ren)
- ☐ Family Coverage
- ☐ No coverage

If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.

7. WAIVER OF COVERAGE SECTION: *(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)*

NOTE: If waiving coverage, please complete this section. Section 4 must also be signed and dated.

Medical Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)
Dental Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)
Vision Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)
Life coverage declined for: ☐ Myself

Reason for Declining Coverage (check all that apply):
- ☐ Covered by spouse's group coverage - Carrier name and ID Number _____
- ☐ Enrolled in other Insurance provided by my employer - Carrier name and ID Number _____
- ☐ Enrolled in Individual coverage - Carrier name and ID Number _____
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare
- ☐ Other (Please explain)
- ☐ No coverage

8. PRIOR HEALTH INSURANCE INFORMATION

Prior Health Care Coverage During the past 2 years (including Anthem):

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
	☐ Employee Only ☐ Employee + child(ren) ☐ Employee + spouse ☐ Family ☐ Other		/ /	/ /

9. 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? ☐ Yes ☐ No

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 ID #	Part A effective date	Part B effective date	*Medicare eligibility reason (check all that apply)*
			☐ Age ☐ Disability ☐ ESRD: Onset Date _____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date
		/ /	/ /

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10. Life and Disability Insurance

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability ☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability ☐ Optional Life: _____ x annual earnings OR $ _____ ☐ Current Income: $ _____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*	☐ Anthem By Design® Short Term Disability-BUY UP ☐ Anthem By Design® Long Term Disability-BUY UP ☐ Anthem By Design® Basic Life-BUY UP (Complete separate election form)	Life Class

Primary Beneficiary	Last name	First name, M.I.	Social Security # - -	Relationship to applicant	Age
Contingent Beneficiary	Last name	First name, M.I.	Social Security # - -	Relationship to applicant	Age

11. SIGNIFICANT TERMS, CONDITIONS AND (UNDERWRITES LIFE AND DISABILITY COVERAGES ONLY) AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 4.***

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 Anthem Blue Cross Blue Shield 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.

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 (underwrites life and disability coverages only) may accept certain persons or conditions for coverage. If accepted, my plan may exclude coverage for pre-existing conditions (Not applicable to MO HMO and Life insurance).
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period (90 days in Kansas) prior to enrollment. This exclusion may last up to 12 months (90 days in Kansas) from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a dependent that is enrolled in the plan prior to his/her 19th birthday.
   I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of prior creditable coverage from the prior Health Insurance Carrier. (Not applicable to MO HMO products.)
4. 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.
5. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

By signing Section 4, 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. ***Thank you for choosing Anthem Blue Cross and Blue Shield.***