Employee Enrollment Application For Small Groups Missouri

Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem) and Anthem Life Insurance Company (Anthem Life), its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary. The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application.

Section A: Application Type

Select one:

☐ New enrollment ☐ Open enrollment (not applicable for Life and/or Disability) ☐ COBRA ☐ Rehire date: (MM/DD/YYYY) ____/____/_____

Select qualifying event (not applicable for Life and/or Disability)

☐ Covered employee's Medicare entitlement ☐ Death ☐ Left employment ☐ Loss of coverage
☐ Loss of dependent child status ☐ Medicare ☐ Reduction in hours

Qualifying event date: (MM/DD/YYYY) ____/____/_____

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required) - -	
Home address — Street or P.O. Box if applicable	City	County	State	ZIP code
County	Primary phone no.	Marital status ☐ Single ☐ Married ☐ Domestic Partner		
Occupation	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

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other — please specify: _____

Employee email address: _____

For myself and any dependents, I'm providing my email address because I agree to receive information about my benefits by email or electronically. This may include my Booklet or Certificate of Coverage, explanation of benefits, Evidence of Insurability underwriting documents, required notices, and helpful or personalized information to get the most out of my benefits. I will make sure Anthem and/or Anthem Life has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by providing my email address information about my dependents may also be sent by email or electronically. I know I (or my enrolled dependents) can update communication preferences or request a free copy of specific materials by going to anthem.com or calling the Member Services number on my ID card.

Section C: Type of Coverage

1. Medical Coverage — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.

Medical product plan name:	Contract code, if known:

Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

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

2. Dental Coverage — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Anthem Dental Prime, Anthem Dental Complete, and Anthem Essential Choice 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

Dental product plan name:	Contract code, if known:

3. Vision Coverage — Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

Vision product plan name:	Contract code, if known:

4. Life/Accidental Death & Dismemberment (AD&D) Coverage

Life/AD&D Products

☐ Basic Life and AD&D	☐ Supplemental/Voluntary Life and AD&D	$ _____ (employee amount)
☐ Basic Dependent Life	☐ Supplemental/Voluntary Dependent Life Spouse	$ _____ (spouse amount)
	☐ Supplemental/Voluntary Dependent Life Child	$ _____ (child amount)

Current annual income: $	Life class no.:

Beneficiary Designation — Attach a separate sheet if necessary.

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		

Total percentages must 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. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse 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 if your Spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse read and sign the following.

Authorization

I am aware that my Spouse, 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.

In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Sign here	**Spouse signature** X	**Spouse name** (print)	**Today's date (MM/DD/YYYY)** / /

5. Disability Coverage

☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability

Current annual income: $	Disability class no.:

Section D: Family Information — All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.

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): / /	
Primary Care Physician (PCP) name		PCP ID no.	Existing patient ☐ Yes ☐ No
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No			

Spouse/Domestic Partner Last name			First name	M.I.	Social Security no.[1] (required) - -
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Spouse ☐ Domestic Partner		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

Dependent Last name			First name	M.I.	Social Security no.[1] (required) - -
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[2] If other, what is relationship?_____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐Yes ☐No If yes, please enter: _____					
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

Dependent Last name			First name	M.I.	Social Security no.[1] (required) - -
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[2] If other, what is relationship?_____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐Yes ☐No If yes, please enter: _____					
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Eligibility subject to Booklet or Certificate of Coverage.

Section E: Prior and Other Group Coverage — Attach a separate sheet if necessary.

Is 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(select all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease: Onset date (MM/DD/YYYY) ____/_____/________

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

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	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 — Proof of coverage will be required. (Proof of coverage not applicable for Life and/or Disability.)

Type of coverage/Declined for — Select all that apply.		**Reason for declining/refusing coverage** — Select all that apply.
☐ Employee	☐ Medical ☐ Dental ☐ Vision ☐ *Life/AD&D (Spouse/Domestic Partner and Dependent coverage not available if life coverage is waived/declined) ☐ Short Term Disability ☐ Long Term Disability	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by their employer's group coverage ☐ Enrolled in individual coverage ☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan: ________________________________ ☐ Other — please explain: ________________________________
☐ Spouse/ Domestic Partner	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life	
☐ Dependent(s)	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life List name of dependents to be waived: ________________________________	

*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, to decline this coverage. I elect of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, where permitted by law, I may be required to provide Evidence of Insurability at my expense.

Sign here only if you are declining coverage.

Sign here	**Applicant signature** X	**Applicant name** (print)	**Today's date (MM/DD/YYYY)** / /

Section G: Terms and Conditions — 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 and/or Anthem Life 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 30 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 (see Booklet or Certificate of Coverage for complete dependent eligibility terms):

- Employee's Spouse/Domestic Partner 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 a child will end on the last day of the month in which the child reaches age 26. For life coverage, only employee's Spouse/Domestic Partner or children age 26 or younger, legally adopted children, and stepchildren are eligible.
- The age limit of 26 does not apply for maintaining enrollment of an unmarried child who cannot support himself or herself because of a mental or physical impairment 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 such mental or physical impairment 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.

Special Enrollment Rights for Medical Coverage Only (see Booklet or Certificate of Coverage for complete enrollment rights)
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.

Section H: Authorizations — Please read this section carefully and then sign below.

In signing this application I represent that:

- For a period of two (2) years from the earlier of the policy date or the issue date, Anthem and/or Anthem Life may deny benefits, rescind my policy or cancel coverage based on material misrepresentation of significant omission found in this application.
- I have read, or have had read to me, the completed application. All statements and answers I have given are true and complete, and I realize any false statement or misrepresentation in the application may result in loss of coverage as set forth above.
- I am an eligible employee and I am requesting coverage for myself and all eligible dependents listed on this application.
- I certify each Social Security number listed on this application is correct.
- I understand that I may not assign any payment under my Anthem and/or Anthem Life program.
- I authorize my employer to deduct any required contributions for this insurance from my wages.
- I am asking for the coverage I chose on this application. 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 and/or Anthem Life reserves the right to accept or decline this application for coverage (and that Anthem Life may accept only certain people or terms for coverage), and that no right is created by my application for coverage.
- I understand that I may not be covered for pre-existing conditions for Long Term Disability, Short Term Disability, Voluntary Long Term Disability, and Voluntary Short Term Disability coverage, 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 authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and that I may provide Anthem with a written request to revoke my authorization at any time.
- By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and/or Anthem Life and me.

Authorization for applicants applying for Life and/or Disability coverage:

1. I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life, consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current application for life and/or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current life and/or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
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. The Life and/or Disability coverages will become effective on the date established by the provisions of the Group Contract and the policy/certificate issued thereunder.
4. 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 Life. 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 a disability insurance benefit and for the duration of the claim if the claim is not for a disability insurance benefit. A photocopy and/or electronic copy is as valid as the original. The applicant or the applicant's authorized representative is entitled to receive a copy of this authorization.

I understand a person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete or misleading information commits a felony; penalties may include imprisonment, fines or a denial of insurance benefits. I also understand all benefits are subject to conditions stated in the Group Contract and the Booklet or Certificate of Coverage.

I give this authorization for myself and on behalf of my eligible dependents, including my Spouse/Domestic Partner, if covered by Anthem and/or Anthem Life, and I am acting as their agent and representative. If my Spouse/Domestic Partner signs this application, he/she is giving authorization on his/her own behalf.

Sign here	**Applicant signature** (or custodial parent's or guardian's signature if applicant is under 18) X	**Today's date (MM/DD/YYYY)** / /
	Spouse/Domestic Partner signature X	**Today's date (MM/DD/YYYY)** / /

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf