Employee Change Form
Missouri Chamber Federation Benefit Plan

Administered by: Anthem

Missouri Chamber FEDERATION
MISSOURI CHAMBER FOUNDATION

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary. *Note: Some changes may be made by accessing anthem.com.*

Section 1: General information

Employer name	Group no.
St. Louis Sports Commission	SN0644

Employee last name	First name	Middle initial

Section 2: Employee information – Required

Reason for change – Required. Check all that apply.

- ☐ Address change
- ☐ Name change
- ☐ Benefit change
- ☐ Add spouse/domestic partner or dependent
- ☐ Cancel spouse/domestic partner or dependent
- ☐ Change Primary Care Physician (PCP)
- ☐ Enrollment in Medicare (Fill in section 5)
- ☐ Other: _____
- ☐ Cancel coverage

☐ **Add** ☐ **Change** ☐ **Cancel**

Event reason – Required. Check all that apply.

☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child
☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce
☐ Other – please explain: _____

Event date/requested effective date – Required: ____ ____ ____ (MMDDYYYY)

Home address – Street and P.O. Box if applicable	City	State	ZIP code

County	Social Security no. (required)[1]	Date of birth (MMDDYYYY)	Sex	Marital status
			☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced

Section 3: Family Information – Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ **Add** ☐ **Change** ☐ **Cancel**

Event reason – Required. Check all that apply.

☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child
☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce
☐ Other – please explain: _____

Event date/requested effective date – Required: ____ ____ ____ (MMDDYYYY)

Spouse/domestic partner last name	First name	M.I.	Social Security no. (required)[1]

Date of birth (MMDDYYYY)	Sex	Disabled	Relationship to applicant
	☐ Male ☐ Female	☐ Yes ☐ No	☐ Spouse ☐ Domestic Partner

Does the Spouse/Domestic Partner have a different address? ☐ Yes ☐ No
If yes, please enter address: _____

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

Reset Form Save and Print

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Primary applicant must be included for spouse/domestic partner and/or dependent coverage eligibility.

Employee name: ______________________ Social Security no.[1]

Section 3: Family Information — Continued

☐ **Add** ☐ **Change** ☐ **Cancel**	**Event reason — Required. Check all that apply.** ☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______ **Event date/requested effective date – Required:** ________ (MMDDYYYY)

Dependent last name	First name	M.I.	Social Security no. (required)[1]

Date of birth (MMDDYYYY)	Sex	Disabled	Relationship to applicant
	☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Other: ______

Does the dependent have a different address? ☐ Yes ☐ No
If yes, please enter address: ______

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

☐ **Add** ☐ **Change** ☐ **Cancel**	**Event reason — Required. Check all that apply.** ☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______ **Event date/requested effective date – Required:** ________ (MMDDYYYY)

Dependent last name	First name	M.I.	Social Security no. (required)[1]

Date of birth (MMDDYYYY)	Sex	Disabled	Relationship to applicant
	☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Other: ______

Does the dependent have a different address? ☐ Yes ☐ No
If yes, please enter address: ______

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

☐ **Add** ☐ **Change** ☐ **Cancel**	**Event reason — Required. Check all that apply.** ☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______ **Event date/requested effective date – Required:** ________ (MMDDYYYY)

Dependent last name	First name	M.I.	Social Security no. (required)[1]

Date of birth (MMDDYYYY)	Sex	Disabled	Relationship to applicant
	☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Other: ______

Does the dependent have a different address? ☐ Yes ☐ No
If yes, please enter address: ______

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

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Employee name: _____ Social Security no.[1] _____

Section 4: Plan/type of coverage

Medical coverage		
Enter network name, product plan name and contract code selected:		
Network name	Product plan name	Contract code, if known
Note for Health Savings Account (HSA) enrollees: If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.		
Member medical coverage – select one: ☐ Employee only ☐ Employee+child(ren) ☐ Employee + Spouse/Domestic Partner ☐ Family		

Section 5: Other health coverage

Are you, or anyone applying for coverage, currently eligible for Medicare? ☐ Yes ☐ No If yes, complete below.				
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Medicare Part D ID no.	Medicare Part D carrier		Medicare Part D effective date	Medicare Part D term date
Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD and disability ☐ End Stage Renal Disease (ESRD)				

Section 5: Other health coverage – Continued.

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
If yes to any of these questions, 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)
	☐ Individual ☐ Group	☐ Health				Start: End:
	☐ Individual ☐ Group	☐ Health				Start: End:
	☐ Individual ☐ Group	☐ Health				Start: End:
	☐ Individual ☐ Group	☐ Health				Start: End:

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Employee name: _____ Social Security no.[1] _____

Section 6: 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 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

- 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 handicap, 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 under the Missouri Chamber Federation Benefit Plan (MBF BP) administered by Anthem. I 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. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company or the plan. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I certify each Social Security number listed on this application is correct.

For a period of two years from the earlier of the policy date or the issue date, Anthem, on behalf of MCF BP, may deny benefits, rescind your policy or cancel coverage based on material misrepresentation of significant omission found in this application.

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.

Signature — Required.

Employee signature	Date (MMDDYYYY)
X	
Spouse/Domestic Partner signature	Date (MMDDYYYY)
X	

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