Administered by:

Anthem AnthemLife Missouri Chamber FEDERATION MISSOURI CHAMBER FOUNDATION

Employee Enrollment Application
Missouri Chamber Federation Benefit Plan (MCF BP)

Instructions:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply only to this employer.

Section 1: Employer/group use – Required. To be filled out by employer.

Employer name		Case no.	Subsection	
Employer address		City	State	ZIP code
Requested effective date	Employee no.	Department name		

Section 2: Reason for application – Required

- ☐ New enrollment
- ☐ Annual open enrollment (not applicable to Life and disability)
- ☐ Add dependent (Fill in section 3)
- ☐ New hire
- ☐ Rehire date: (MMDDYYYY)
- ☐ COBRA/State Continuation – Qualifying event: _____
  Event date: (MMDDYYYY)
- ☐ Waiver (To decline ALL benefits skip to section 11)

Section 3: Status change/event – Required, if you checked "Add dependent" option in section 2.

Event date: (MMDDYYYY)

- ☐ Marriage
- ☐ Birth
- ☐ Adoption (Attach legal documentation)
- ☐ Legal guardianship (Attach legal documentation)
- ☐ Loss of benefits (reason): _____
- ☐ Terminated employment
- ☐ Other: _____

Section 4: Employee information – Required

Last name	First name	M.I.	Social Security no. (Required)	
Date of birth (MMDDYYYY)	Age	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner	
Home phone	Business phone	Email address		
Address		City	State	ZIP code
County		Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Hospitalized: ☐ Yes ☐ No		
Occupation		Full-time hire date	Hours working per week	

Income reported by: ☐ W-2 ☐ 1099 ☐ Other: _____

Reset Form Save and Print

Employee name: _____ Social Security no. _____

Section 5: Plan/type of benefits — Required. To decline a plan type, check "No benefits". If you are waiving all benefits, go to section 11.

MCF BP Medical

Plan selected: _____ Network: _____

Type of medical benefits: ☐ Employee only ☐ Employee+spouse/domestic partner ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits

Anthem Dental

Plan selected: _____ Contract code: _____

Type of dental benefits: ☐ Employee only ☐ Employee+spouse/domestic partner ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits

Anthem Vision

Plan selected: _____ Contract code: _____

Type of vision benefits: ☐ Employee only ☐ Employee+spouse/domestic partner ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits

Anthem Life/AD&D coverage

If you select life coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life and Accidental Death and Dismemberment
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse/Domestic Partner . . . . . $_____ (spouse/domestic partner amount)
☐ Optional Supplemental/Voluntary Dependent Life Child . . . . . $_____ (child amount)

Current annual income $_____	Occupation	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 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. 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'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 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.

Spouse/Domestic Partner signature **X**	Spouse/Domestic Partner name	Date (MM/DD/YYYY)

Employee name: _____ Social Security no. _____

Disability coverage		
If you select disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.		
☐ Short Term Disability ☐ Long Term Disability	☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability	
Current annual income $_____	Occupation	Disability class no.

Section 6: Family information — Required. List only dependents you wish to enroll. Attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under section 9, Significant Terms, Conditions and Authorizations, prior to answering the questions in section 6.

Spouse/domestic partner last name	First name	M.I.	Social Security no. (Required)
Date of birth (MMDDYYYY) Sex ☐ Male ☐ Female	Relationship to employee ☐ Spouse ☐ Domestic Partner		
Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____			
If spouse/domestic partner address is different than employee, please provide full address			

Dependent last name	First name	M.I.	Social Security no. (Required)
Date of birth (MMDDYYYY) Sex ☐ Male ☐ Female	Full-time student ☐ Yes ☐ No	Relationship to employee ☐ Child ☐ Other: _____	
Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____			
Court ordered health care coverage? ☐ Yes ☐ No If yes, attach legal documentation.			
If dependent address is different than employee, please provide full address			

Dependent last name	First name	M.I.	Social Security no. (Required)
Date of birth (MMDDYYYY) Sex ☐ Male ☐ Female	Full-time student ☐ Yes ☐ No	Relationship to employee ☐ Child ☐ Other: _____	
Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____			
Court ordered health care coverage? ☐ Yes ☐ No If yes, attach legal documentation.			
If dependent address is different than employee, please provide full address			

Employee name: _____ Social Security no. _____

Section 7: Other health coverage – Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.				
On the day your benefits begin, list family members, including yourself, who will be covered by any other health coverage				
Provide name, phone number and address of the HMO or insurance company			Policy/certificate no.	Effective date (MMDDYYYY)
Policy/certificate holder name	Social Security no.		Date of birth (MMDDYYYY)	Relationship to employee
Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ 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 8: Prior health coverage – Required

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.		
Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No	Policy/certificate no.	
Group name/ID no.	Date policy in effect	Date policy terminated
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No		
List prior carrier(s)	Date policy in effect	Date policy terminated
Please check the type of prior coverage: ☐ Employee ☐ Employee+Spouse/Domestic Partner ☐ Employee+Child(ren) ☐ Employee+Spouse/Domestic Partner+Child(ren)		
Termination reason ☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other ☐ Death of spouse/domestic partner ☐ COBRA/State Continuation coverage exhausted ☐ Group plan terminated		

Employee name: _____ Social Security no. _____

Section 9: Significant Terms, Conditions and Authorizations (TERMS) — Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that, with the exception of an assignment of benefits to a treating provider, I may not assign any payment under my Anthem and/or Missouri Chamber Federation Benefit Plan (MCF BP) program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the applicable premium and/or premium equivalent rate for the benefits applied for.
3. I am asking for the benefits 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.
4. I understand that, to the extent allowed by law, Anthem or Anthem on behalf of MCF BP, if applicable, reserves the right to accept or decline this application for benefits and that no right is created by my application for benefits.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
6. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for these benefits.
7. I certify each Social Security Number listed on this application is correct. I understand that Anthem is required by the Internal Revenue Service to collect this information.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of benefits. My answers to all questions are true to the best of my knowledge, and I understand that Anthem and MCF BP rely on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in benefits or applicable premium and/or premium equivalent rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of benefits. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature — Required, if you are applying for benefits. Please review your application for errors or omissions.

Read section 9 carefully before signing.
I have read and understand the language in the Terms section of this application and agree to all of its terms.

Employee signature	Date (MMDDYYYY)
X	

Section 11: Life and/or Disability Authorization — Please read this section carefully before signing the application.

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 Insurance Company (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 representatives to evaluate and adjudicate my current application for life 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 solely to assist with the evaluation and adjudication of my current life 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 collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem.

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.

These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits, subject to the conditions/provisions of the policy.

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 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 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 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.

Signature — Required.

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

Employee name: _____ Social Security no. _____

Section 12: Waiver/Declining coverage – Complete for yourself and/or any eligible dependents. Check all that apply.

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

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

Dental coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

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

Vision coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

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

Life coverage

***Life and 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

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Reason for declining coverage – check all that apply:
- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life 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.

Disability coverage

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Employee name: _____ Social Security no. _____

Section 12: Waiver of benefits — Complete for yourself and/or any eligible dependents. Check all that apply.

Check if applicable:

☐ I have been given an opportunity to apply for Anthem and/or MCF BP benefits and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such benefits at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse/domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. If enrollment is not requested within 31 days, my dependents or I are not eligible to enroll in this plan until the next open enrollment. 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 dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents 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.

Signature — Required, if you want to waive benefits for yourself and your dependents.

Employee signature	Date (MMDDYYYY)
X	

Administered by:

Anthem AnthemLife Missouri Chamber FEDERATION MISSOURI CHAMBER FOUNDATION

Employee Health Questionnaire
Missouri Chamber Federation Benefit Plan (MCF BP)

Employee name	Height	Weight	Social Security no.	Group name
Spouse/domestic partner name	Height	Weight	Benefits: ☐ Employee only ☐ Employee/Spouse/domestic partner ☐ Employee/Child(ren) ☐ Family	
Dependent 1	Height	Weight	Dependent 2	Height / Weight
Dependent 3	Height	Weight	Dependent 4	Height / Weight
Dependent 5	Height	Weight	Dependent 6	Height / Weight

Please answer the following questions for yourself AND any eligible dependents

Please note that no one will be denied benefits on an individual basis due to answers provided below.

1. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary with the exception of AIDS/HIV? ☐ Yes ☐ No
   If "Yes", please explain below.
2. In the past five years have you or any of your dependents been diagnosed or treated for any of the following? ☐ Yes ☐ No
   If "Yes ", please check condition(s) that apply.

☐ Heart/circulatory condition	☐ Seizures/epilepsy	☐ Lung disorder
☐ Cancer/tumor/growth	☐ Depression	☐ COPD
☐ Disorder of the blood or immune system	☐ Alcohol or drug abuse/dependency	☐ Emphysema
☐ Stroke	☐ Kidney disease	☐ Back/disk disorder
☐ Aneurysm	☐ Kidney stones	☐ Multiple sclerosis
☐ High blood pressure	☐ Liver or pancreas disorder	☐ Muscular dystrophy
☐ Diabetes (list age of onset below)	☐ Digestive/intestinal disorder	☐ Infertility/reproductive organ disorder
☐ Mental/nervous disorder	☐ Ulcerative colitis	☐ Congenital disease or birth defect
☐ Parkinson's disease	☐ Crohn's disease	☐ Cerebral palsy
☐ Migraine/cluster headaches	☐ Lupus	☐ Transplants
☐ Arthritis	☐ Obesity	☐ Other: _____

   ☐ Currently pregnant? If, yes, due date: ____ (MMDDYYYY)
   If "Yes", please explain below.
3. Do you or your dependents regularly take medication? ☐ Yes ☐ No
   If "Yes", please explain below.
4. In the past five years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
   If "Yes", please explain below.

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

Question no.	Individual name	Diagnosis	Treatment	Medication	Onset date	Treatment date(s)	Hospitalized	Surgery	Recovered
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee name: _____ Social Security no. _____

I represent that all answers on this Questionnaire 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 and MCF BP 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 benefits, applicable premium and/or premium equivalent rates. Material misrepresentations or significant omissions in this application may result in increased applicable premium and/or premium equivalent rates, or benefits being denied, rescinded or cancelled.

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.

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 HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164). I also understand that under the HIPAA Privacy Regulations, 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.

3904.06 I understand that the length of time such authorization shall remain valid shall be no longer than 30 months from the date the authorization is signed.

I agree that this executed Questionnaire will become part of the application and any contract issued on it.