Enrollment Application
Group size 51+ eligible employees

Anthem BlueCross BlueShield
Community Insurance Company

Anthem Life

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 to this employer.

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name		Employer address		
Group no.	Sub-group no./ Life division no.	Requested effective date	Life classification	Employee no./Dept. name

SECTION 2: REASON FOR APPLICATION - Required

☐ New enrollment ☐ Annual open enrollment (N/A to Life)	☐ COBRA Qualifying event_____ event date_____ ☐ Waiver (To decline ALL coverage skip to Section 13)	☐ New hire ☐ Rehire date_____	☐ Add dependent (Fill in Section 3)

SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date				
	☐ Marriage ☐ Birth	☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation)	☐ Loss of coverage (reason) _____ ☐ Other_____	☐ Termed employment

SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 13.

Medical
If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.

Type of coverage

☐ HMO ☐ POS ☐ PPO	☐ Anthem Essential℠ PPO ☐ Lumenos® HSA PPO*	☐ Lumenos® HRA PPO ☐ Lumenos® HIA PPO ☐ Blue Traditional®	☐ Blue Priority℠ (a health insuring corporation product or "HIC") ☐ Lumenos® Health Incentive Account Plus PPO ☐ Lumenos® Deductible First HRA PPO	☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

If multiple Medical Plans are available, write plan number:

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

Dental
To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.

☐ PPO_____ ☐ Traditional ☐ Dental Blue®100/200/300 ☐ Dental Blue® 100	**Type of coverage** ☐ Employee only ☐ Employee+child(ren) ☐ No coverage	☐ Employee+spouse ☐ Family coverage	**Type of coverage** ☐ Employee only ☐ Employee+child(ren) ☐ No coverage	☐ Employee+spouse (DP) ☐ Family coverage	☐ Life (Fill in Section 8)	

SECTION 5: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)

Sex ☐ M ☐ F	☐ Single ☐ Married ☐ Divorced	Height	Weight	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 ☐ W2 ☐ 1099 ☐ Other_____

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 11, 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	Height	Weight	Sex ☐ M ☐ F	Relationship to employee ☐ Spouse ☐ Domestic Partner	Currently hospitalized or disabled ☐ Yes ☐ No (If yes, give reason)

If spouse/DP address is different than employee, please provide full address

Employee name _____ Social security no._____

SECTION 6: FAMILY INFORMATION – CONTINUED – 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 11, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Dependent

Last name	First name	M.I.	Social security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No (If yes, give reason)

Court ordered health care coverage	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes,attach legal documentation)	

Dependent

Last name	First name	M.I.	Social security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No (If yes, give reason)

Court ordered health care coverage	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

SECTION 7: HEALTH QUESTIONNAIRE – Please answer questions for yourself and all eligible dependents, including spouse and domestic partners

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

1. Has anyone been?
   ☐ Treated for a serious illness ☐ Been hospitalized ☐ Had surgery in the past 5 years ☐ Is currently hospitalized
   ☐ Been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary (with the exception of AIDS / HIV)?
2. Is anyone currently being treated or been advised to seek treatment or counseling for any of the following? ☐ Yes ☐ No
   If yes, please check condition(s) that apply
   ☐ Cancer ☐ Diabetes ☐ Mental illness ☐ Liver disease ☐ Back/spinal disorder ☐ Crohn's disease/ulcerative colitis
   ☐ Heart disease ☐ Muscular disorder ☐ Alcoholism ☐ Kidney disorder ☐ Chemical dependency ☐ Chronic respiratory disease
   ☐ Stroke ☐ Brain tumor ☐ Chest pain ☐ High blood pressure ☐ Nervous system disorders ☐ Other_____
   ☐ Blood disorders ☐ Transplants ☐ Obesity

   If "Cancer" please enter location:_____
   Date of last treatment: _____ In Remission? ☐ Yes ☐ No
3. Do you or your dependents regularly take medication? ☐ Yes ☐ No If yes, please explain below
4. Do you or a covered dependent have a birth defect? ☐ Yes ☐ No If yes, please explain below
5. Is anyone currently pregnant? ☐ Yes ☐ No If yes, provide a due date: _____
   Any current complications? ☐ Yes ☐ No Infertility treatment? ☐ Yes ☐ No
6. In the past 5 years have you or any of your dependents ever been diagnosed with AIDs or an AIDS-related condition? ☐ Yes ☐ No
   If yes, please explain below

If you answered "YES" to any question in Health Questionnaire above, please provide complete details below

Question no.	Name of Individual	Diagnosis and Date	Treatment and Date(s)	Medication	Hospitalized/Surgery/ Recovered
					☐ Hospitalized ☐ Surgery ☐ Recovered
					☐ Hospitalized ☐ Surgery ☐ Recovered
					☐ Hospitalized ☐ Surgery ☐ Recovered
					☐ Hospitalized ☐ Surgery ☐ Recovered
					☐ Hospitalized ☐ Surgery ☐ Recovered
					☐ Hospitalized ☐ Surgery ☐ Recovered

Employee name _____ Social security no._____

SECTION 8: LIFE AND DISABILITY INSURANCE - Required, if this type of coverage was selected in Section 4.

Current Income $_____ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Life Class

☐ Basic Life ☐ Optional Life _____ x Annual Earnings ☐ Basic AD&D ☐ Short-Term Disability_____
☐ Dependent Life OR $_____ ☐ Optional AD&D ☐ Long-Term Disability _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

☐ Short-Term Disability_____% ☐ Long-Term Disability_____% ☐ Basic Life

Primary beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

Contingent beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

SECTION 9: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your coverage begins, 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

Policy/certificate holder name	Social security no.	Date of birth	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 & Disability ☐ End Stage Renal Disease (ESRD)

SECTION 10: 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 termed

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 termed

Please check the type of prior coverage ☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)

Termination reason:
☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other
☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated

SECTION 11: 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 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 Blue Cross and Blue Shield at any time.

Employee name _____ Social security no._____

SECTION 11: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

1. I understand that I may not assign any payment under my Community Insurance Company (Anthem) program, unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. 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.
4. 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, unless I applied for HMO/HIC coverage, in which case there is no such exclusion.
5. 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.
6. If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
7. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
8. 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 CFR. Parts 160 & 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.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies 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 coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. 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. 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.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

SECTION 12: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 11 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 X	Date

SECTION 13: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ Medical	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Dental	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Vision	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Life	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ All	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.

Check all that apply:

☐ I have been given a chance to apply for Anthem Blue Cross and Blue Shield coverage, and after careful thought, I have decided not to take this offer. If I want to apply for coverage at a later date, I can, based on established methods. If I have decided not to take this offer of coverage for myself or my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents later, as long as I ask to sign up within 31 days after other coverage ends. If my dependent or I are late enrollees, we may be subject to pre-existing conditions restrictions or waiting periods set out in the group certificate. The pre-existing exclusion may not apply to dependents enrolled in the plan before their 19th birthday. Also, 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 if I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may sign up under two more 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 aid program)

In these cases, I may be able to enroll myself and my dependents if I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given a chance to apply for the group life benefits offered by my employer/group. The benefits have been explained to me. I and/or my dependent(s) have decided not to join. My dependent(s) or I were not pressured by my employer/group, agent or life carrier, to say no to this coverage, but instead we chose to say no of our own accord. I agree that if I want to ask for coverage in the future, I may be asked to give proof of insurability at my own cost.

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature X	Date