Employee Enrollment Application
For 51+ employee groups
Ohio

Anthem Blue Cross and Blue Shield
Underwritten by Community Insurance Company or Anthem Insurance Companies, Inc.

AnthemLife

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

- ☐ New enrollment
- ☐ Annual open enrollment (not applicable to life and disability)
- ☐ New hire
- ☐ Rehire – Rehire date: _____ (MM/DD/YYYY)
- ☐ Marriage – Date of marriage: _____ (MM/DD/YYYY)
- ☐ Birth of child
- ☐ Add dependent (Fill in section 4)
- ☐ Loss of eligibility for other coverage – Date previous coverage ended: _____ (MM/DD/YYYY)
- ☐ COBRA – Select qualifying event
  - ☐ Left employment
  - ☐ Reduction in hours
  - ☐ Death
  - ☐ Medicare
  - ☐ Loss of dependent child status
  - ☐ Divorce or legal separation
  - ☐ Covered employee's Medicare entitlement

  Qualifying event date: _____ (MM/DD/YYYY)
- ☐ Waiver (To decline ALL coverage skip to section 8.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Large Group 51–99 options

☐ Blue Access (PPO)
☐ Blue Access (PPO) HSAs
☐ Blue Access (PPO) HSAs (with Copay)
☐ Blue Access Options PPO (3-Tier)
☐ Blue Access Options PPO (3-Tier) HSAs

Large Group 100+ options

☐ Blue Access (PPO)
☐ Blue Access (PPO) HSAs
☐ Blue Access (PPO) HSAs (with Copay)
☐ Blue Access Options PPO (3-Tier)
☐ Blue Access Options PPO (3-Tier) HSAs
☐ Blue Access (PPO) HRAs
☐ Blue Access (PPO) HRAs (with Copay)
☐ Blue Access (PPO) Deductible First HRAs

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Prime Consumer Choice ☐ Complete Essential Choice ☐ Complete Consumer Choice
☐ Other: _____

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Life and disability coverage

If you select life and/or disability 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
☐ 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 . . . . . $_____ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child. . . . . $_____ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income – For employer/Anthem use	Occupation	Life and disability class no. – For employer/Anthem use
$_____		

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Social Security no.* (required)

Life and disability coverage – Continued

Primary beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent beneficiary – If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

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. 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.

Spouse/Domestic Partner signature **X**	Spouse/Domestic Partner name	Date

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Social Security no.* (required)

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or 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.

Spouse/Domestic Partner last name | First name | M.I. | Social Security no.* (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

Dependent last name | First name | M.I. | Social Security no.* (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other 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: ____________

Dependent last name | First name | M.I. | Social Security no.* (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other 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: ____________

Dependent last name | First name | M.I. | Social Security no.* (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other 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: ____________

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Social Security no.* (required)

Section 5: Prior and other group coverage

Are you or 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 (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: ______ (MM/DD/YY)

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

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

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.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

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Social Security no.* (required)

Section 6: 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 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 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.
5. 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.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
7. 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 certify each Social Security number listed on this application is correct.

I have read and accept the 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.

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.

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

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature – Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 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 (MM/DD/YYYY)
X	

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Social Security no.* (required)

Section 8: Waiver/Declining coverage

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 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 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 covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life and disability coverage

***Life/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

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

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
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*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.

Sign here only if you are declining coverage.

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

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