

Employee Enrollment Application/Change Form

EmployeeElect for 1-50 Member Small Groups



For your convenience, this single form may be used for enrollment or changes in Medical, Dental, Vision, Life and Disability coverage(s). Please complete in ink, using all capital letters. To avoid any delays, please answer all questions completely, be sure to sign and date your application, and return to your employer. You have the option of detaching the Health Statement at the end of this application, and submitting that page to your employer in a sealed envelope.

Group Number

1a. Medical Coverage...please ask your employer which medical plans are available, and check your selection:

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Premier PPO \$15 Copay | <input type="checkbox"/> PPO \$35 Copay GenRx | <input type="checkbox"/> Premier HMO | <input type="checkbox"/> PPO Basic |
| <input type="checkbox"/> Premier PPO \$25 Copay | <input type="checkbox"/> PPO \$45 Copay GenRx | <input type="checkbox"/> Classic HMO | <input type="checkbox"/> PPO Standard |
| <input type="checkbox"/> PPO \$30 Copay | <input type="checkbox"/> PPO 2000 (HSA-compatible) | <input type="checkbox"/> Premier HMOSelect | <input type="checkbox"/> HMO Basic |
| <input type="checkbox"/> PPO \$40 Copay | <input type="checkbox"/> PPO 3500 (HSA-compatible) | <input type="checkbox"/> Classic HMOSelect | <input type="checkbox"/> HMO Standard |

Other

If HMO, be sure to provide Primary Care Physician (PCP) number in section 3

1b. Dental Coverage...please ask your employer which dental plans are available, and check your selection:

- | | |
|---|--|
| <input type="checkbox"/> Anthem Blue Dental PPO Option 1 | <input type="checkbox"/> Anthem Blue Dental PPO Plus Option 1 |
| <input type="checkbox"/> Anthem Blue Dental PPO Option 1 with ortho | <input type="checkbox"/> Anthem Blue Dental PPO Plus Option 1 with ortho |
| <input type="checkbox"/> Anthem Blue Dental PPO Option 2 | <input type="checkbox"/> Anthem Blue Dental PPO Plus Option 2 |
| <input type="checkbox"/> Anthem Blue Dental PPO Option 3 | <input type="checkbox"/> Anthem Blue Dental PPO Plus Option 3 |
| <input type="checkbox"/> Anthem Blue Dental PPO Option 3 with ortho | <input type="checkbox"/> Anthem Blue Dental PPO Plus Option 3 with ortho |
| <input type="checkbox"/> Anthem Blue Dental PPO Option 4 | <input type="checkbox"/> Anthem Blue Dental PPO Plus Option 4 |

Other

1c. Vision Coverage...please ask your employer which vision plans are available, and check your selection:

- Blue View OR Blue View Plus

1d. Life and Disability Coverage...please ask your employer what coverage(s) are being offered, and check your selection(s):

- | | | | |
|---|--|--|------------------------------------|
| <input type="checkbox"/> Life and AD&D | <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Supplemental Life; please select one: | |
| <input type="checkbox"/> Dependent Life | <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$25,000 |
| | <input type="checkbox"/> Protection Pack | <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$100,000 |

Primary Beneficiary—Name	Relationship	Social Security Number
Contingent Beneficiary—Name	Relationship	Social Security Number

Please use a separate sheet, if needed, to list additional beneficiaries.

2. Employee Information...please provide us with information needed to process your request (must be completed by employee):

Reason for completing application:

- New Enrollment
 Changing Coverage
 Changing PCP
 Changing Beneficiary
 Changing Personal Information
 COBRA: Qualifying Event _____ Effective Date _____

Last Name	First Name	M.I.	Social Security or Member No.
Mailing Address for Member Correspondence		Apt No.	Do you have a Spouse/ Common-law Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No
City, State, ZIP Code		# of Dependents including Spouse	
Employer Name		Spouse's Social Security No.	
Occupation/Job Title		Home Phone No. ()	
Hire Date		Business Phone No. ()	
<input type="checkbox"/> Part time	Salary (Required)	<input type="checkbox"/> Hourly	# of Hours Worked per Week
<input type="checkbox"/> Full time	\$	<input type="checkbox"/> Weekly	E-Mail Address
		<input type="checkbox"/> Monthly	
		<input type="checkbox"/> Yearly	



Social Security or Member No.

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3. Enrollment Information...please give us necessary information to enroll you and your dependent(s):

Gender	Last Name	First Name	MI	Height	Weight	Birthdate	Disabled?	Check if applicable; see notes below for additional action.	HMO Only Primary Care Physician (PCP) Number ⁵	Current Patient?
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse						<input type="checkbox"/> Yes ¹ <input type="checkbox"/> No	<input type="checkbox"/> Retaining last name <input type="checkbox"/> Common-law ²		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Other Dependent						<input type="checkbox"/> Yes ¹ <input type="checkbox"/> No	<input type="checkbox"/> Over-age ³ <input type="checkbox"/> Court-ordered ⁴		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Other Dependent						<input type="checkbox"/> Yes ¹ <input type="checkbox"/> No	<input type="checkbox"/> Over-age ³ <input type="checkbox"/> Court-ordered ⁴		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Other Dependent						<input type="checkbox"/> Yes ¹ <input type="checkbox"/> No	<input type="checkbox"/> Over-age ³ <input type="checkbox"/> Court-ordered ⁴		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Other Dependent						<input type="checkbox"/> Yes ¹ <input type="checkbox"/> No	<input type="checkbox"/> Over-age ³ <input type="checkbox"/> Court-ordered ⁴		<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: (additional information/attachments needed):
 1 Attach Mentally/Physically Disabled Dependent Form
 2 Attach Common-Law Marriage Affidavit
 3 Initial the Over-age Dependent Affidavit in Section 6
 4 Attach Court Order for court-ordered health coverage
 5 Choose a PCP (one may be assigned if not selected here)
 If any enrolling dependent(s) do not live at the address listed in Section 2 on page 1, please provide their address(es) on a separate piece of paper.

4. Declination...complete this section only if you want to decline coverage(s) for yourself and/or any eligible dependent(s):

Type of Coverage:	Declined for:	Please write in "A," "B," "C," etc. per the list below to identify reason for declining (proof of other coverage may be required).
Medical plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	A Covered by another group plan; carrier and ID are: _____ B Covered by individual policy; carrier and ID are: _____ C Covered by military service insurance D Have no other insurance coverage and am not interested E Covered by Medicare (please provide information in Section 5b) F Other: _____
Dental plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	
Vision plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	
Life/Disability	<input type="checkbox"/> Self <input type="checkbox"/> Dependents	

I UNDERSTAND THAT:

- If I decline health coverage under a PPO policy and have no other group or individual health coverage at this time, my dependent(s) and I may enroll as a late entrant(s), subject to an 18-month pre-existing condition waiting period.
- If I decline health coverage under an HMO policy I will not be able to enroll until the next open enrollment period. My dependents and I may enroll subject to a 6-month pre-existing condition waiting period or within 31 days after a qualifying event, as defined by my plan.
- If I decline health coverage for myself and/or my dependent(s) (including my spouse) because of other group or individual health insurance coverage, I may in the future be able to enroll myself and/or my dependent(s) in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new 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 for adoption.
- I may be required to submit additional information upon request.
- If I decline life and/or disability coverage for any reason, my dependents and I may enroll in the future as late entrants only if we provide satisfactory proof of insurability.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application. The plan has been explained to me, and I decline to participate.

X _____
 Employee Signature if declining coverage for self/dependent(s)

 Date



Social Security or Member No.									

5a. Other Coverage...

please provide requested information if you or your dependent(s) have, or had in the past 90 days, any coverage other than the applied-for coverage:

Name of Person Covered	TYPE (check one)		COVERAGES (check as many as apply)			Name of Carrier	STATUS (check one)		DATES (if applicable)	
	Individual	Group	Medical	Dental	Prescription		Have now and intend to keep	Had in last 90 days	Start	End

5b. Medicare coverage...*please provide information if you or your dependent(s) are currently receiving Medicare benefits:*

Name (First, Middle Initial, Last)	Medicare Number	Effective Date			Reason for Disability (If under age 65)
		Part A	Part B	Part D	

Note: If you are eligible for Medicare, Anthem Blue Cross and Blue Shield may not duplicate Medicare benefits.

Please attach separate sheets, if more space is needed.

6. Over-age Dependent Affidavit

By initialing below, I verify and attest that my dependent(s), including over-age dependents ages 19 through 24, is/are unmarried and financially dependent on me or, regardless of age; is/are financially or otherwise dependent on me due to mental and/or physical disability; or is/are dependent on me due to a court order and therefore is/are eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem Blue Cross and Blue Shield or HMO Colorado within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem Blue Cross and Blue Shield or HMO Colorado and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year until the maximum age limit has been reached, as specified by the certificate. I understand that Anthem Blue Cross and Blue Shield or HMO Colorado reserves the right to request, at any time, proof of over-age dependency.

Initials _____



Social Security or Member No.									

8. Employee Authorization , Notice and Representations for Life and/or Disability Coverage

My signature on page 4 of this application acknowledges my agreement with the Authorization below.

I understand that Anthem Life Insurance Company (Anthem Life) 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 applicable federal and state law. I also understand that under applicable federal and state law, 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 these laws by writing to Anthem Life.

For the purpose of evaluating my Health Statement for Anthem Life coverage, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me or my health or that of my family for whom this Health Statement is made or their health to give Anthem Life or its reinsurers any such information. I also authorize Anthem Life or its reinsurers to release any information regarding me or my health or that of my family for whom insurance application is made to the Medical Information Bureau Inc.; or other life insurance companies with which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand this information will be used by Anthem Life to determine eligibility for insurance. This information includes any record or knowledge about medical history, including information contained in such records relating to sensitive services such as mental health, psychiatric, substance abuse, reproductive health, and information about HIV virus or AIDS, sexually transmitted or other communicable diseases. This includes but is not limited to all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. This authorization, for purposes of processing this application, will be valid from the date signed for a period of 30 months, and a photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy. For the purposes of processing a claim under this coverage, this authorization is valid for the duration of the claim.

I certify that I have read, or have had read to me, the completed Health Statement and that I realize any false statement or misrepresentation in the Health Statement may result in loss of coverage under the policy.

EMPLOYEE REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE

Your signature on this application acknowledges your agreement with the following representations.

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract subject to change by my written notice to my employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages, if necessary, for the required premium for the coverage for which I have applied.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I am applying for the coverage selected on this application. If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
5. I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provision as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge, and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). A photocopy is as valid as the original.

I give this representation for and on behalf of myself and my eligible dependents, including my children and my spouse if covered by the plan. I am acting as their agent and representative.

The employee and any person authorized to act on behalf of the employee, is entitled to receive a copy of this representation and will be provided a copy of this application upon their request.

IMPORTANT NOTICE

Information regarding your insurability will be treated as confidential. Anthem Life, or its reinsurers may, however, make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is PO Box 105, Essex Station, Boston, MA 02112.

Anthem Life, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. You may want to keep a copy of this statement for your records.



Employee Name: _____

Social Security or Member No.									

Group Name: _____

9. Health Statement ...please complete for yourself and all eligible family members. Use a separate sheet, if necessary.
Privacy Note: Anthem Blue Cross and Blue Shield and HMO Colorado will not give this confidential information to your employer, and you have the option of detaching this Health Statement page and submitting it to your employer in a sealed envelope.

All questions must be answered "Yes" or "No." INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION, WHICH MAY DELAY THE PROCESSING.

Has any person listed on this application had or consulted, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions within the past 5 years?

1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, hyperlipemia or arteriosclerosis or any other disorder of the heart, blood or blood vessels Yes No
2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver? Yes No
3. Cancer, cyst, or tumor? Yes No
4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction? Yes No
5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system? Yes No
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system? Yes No
If epileptic, date of last seizure:
7. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? Yes No
8. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? Yes No
9. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems? Yes No
10. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? Yes No
11. Taken medicine as prescribed by a physician or other health practitioner in the last 12 months? Yes No
- 12a. Is any female to be covered currently pregnant? Yes No
If yes, due date (month):
- 12b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? Yes No
13. Does anyone listed on this application use tobacco products? Yes No

If you answered "Yes" to any of the above questions 1-12a, please complete the following (use additional sheets if necessary):

Question # ____ Name of patient _____ Condition treated _____ Dates of treatment: Start _____ End _____ Treatment rendered _____ Medication and dosage taken _____ Dates taken: Start _____ End _____	Question # ____ Name of patient _____ Condition treated _____ Dates of treatment: Start _____ End _____ Treatment rendered _____ Medication and dosage taken _____ Dates taken: Start _____ End _____
Question # ____ Name of patient _____ Condition treated _____ Dates of treatment: Start _____ End _____ Treatment rendered _____ Medication and dosage taken _____ Dates taken: Start _____ End _____	Question # ____ Name of patient _____ Condition treated _____ Dates of treatment: Start _____ End _____ Treatment rendered _____ Medication and dosage taken _____ Dates taken: Start _____ End _____

