

Employer Enrollment Application/Change Form

EmployeeElect for 1-50 Member Small Groups



Please Complete in Ink

Purpose:	Coverage Type(s):	Requested Effective Date:
<input type="checkbox"/> Submit a new application <input type="checkbox"/> Request change(s) for Group No. _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	(mm-dd-yyyy)

1. Please tell us about your company...

Company Name		Group Administrator Name
Street Address		County
City, State, ZIP Code		Phone Number ()
Billing Address (if different from above)		FAX Number ()
City, State, ZIP Code (if different from above)		E-mail Address
Nature of Business (please be specific)	Employer Tax ID Number	Standard Industrial Classification Code
Organization Type <input type="checkbox"/> Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Government Unit/Agency <input type="checkbox"/> Partnership <input type="checkbox"/> Labor Union <input type="checkbox"/> Organization Exempt from Income Tax <input type="checkbox"/> Other: _____		Date Business Established (mm-dd-yyyy)

2. Medical Coverage Preferences... what payment option and medical plan(s) would you like to select?

2a. My employer medical contribution each month will be:

Traditional option-I will contribute (50% to 100%): _____% per employee _____% per dependent.

Fixed dollar option-I will contribute (at least \$125 in \$5 increments): \$ _____ per employee \$ _____ per dependent.

2b. I choose to offer:

ALL PLANS

OR

DESIGNATED PLAN(S) (designate single plan or mix and match by checking as many plans below as desired):

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

*HMOSelect plans are only available in specific employer- based geographic areas.

OR

COLORADO-MANDATED PLAN(S)

PPO Basic PPO Standard HMO Basic HMO Standard

Other Use: _____



3. Dental Coverage... what payment option and dental plan(s) would you like to select?

3a. My employer dental contribution each month will be (50% to 100% for stand-alone coverage or 25% to 100% if dental coverage is purchased with medical coverage): _____% per employee _____% per dependent.

3b. I choose to offer (please check as many as apply):

- Anthem Blue Dental PPO Option 1 with ortho
- Anthem Blue Dental PPO Option 1
- Anthem Blue Dental PPO Option 2
- Anthem Blue Dental PPO Option 3 with ortho
- Anthem Blue Dental PPO Option 3
- Anthem Blue Dental PPO Option 4
- Anthem Blue Dental PPO Plus Option 1 with ortho
- Anthem Blue Dental PPO Plus Option 1
- Anthem Blue Dental PPO Plus Option 2
- Anthem Blue Dental PPO Plus Option 3 with ortho
- Anthem Blue Dental PPO Plus Option 3
- Anthem Blue Dental PPO Plus Option 4

Other Use: _____

4. Vision Coverage Preferences... what payment option and vision plan(s) would you like to select?

4a. My employer vision contribution each month will be (50% to 100%): _____% per employee % _____ per dependent.

4b. I choose to offer: Blue View **AND/OR** Blue View Plus

5. Life/Disability Benefit Selections... what employer contribution(s) and product(s) would you like to select?

Life Products - Employer Contributions:

Per Employee _____% (25% to 100%)
Per Dependent _____% (Optional)

Term Life

Check only one schedule: for Schedules A&B, specify amount (at least \$15,000 in \$1,000 increments; maximum \$200,000):

- Schedule A** - Benefit is the same for all job titles: \$_____
- Schedule B** - Benefit differs by job title:
Class I, officers, managers, supervisors: \$_____
Class II, all other group members: \$_____
(Class I amount cannot exceed 2.5 times Class II amount)
- Schedule C** - Benefit is a percentage of salary; check one of the following for **all** employees:
 1 x annual salary (please provide list of employees and base salaries)
 2 x annual salary

Supplemental Life

Only available if other Life options are also selected.
 Check for Supplemental Life (may be 100% employee paid)

Dependent Life

Check only one (please note that Option 1 is only available if employee Life benefit is \$20,000 or more):

- Option 1: \$10,000 spouse; \$10,000 children 6 mo to 19 yrs (thru age 24 if full-time student); \$1,000 children under 6 mo
- Option 2: \$5,000 spouse; \$5,000 children 6 mo to 19 yrs (thru age 24 if full-time student); \$500 children under 6 mo

Disability Products - Employer Contributions (25% to 100%):

Long Term Disability (LTD) _____%
Short Term Disability (STD) _____%

LTD and STD

Check one of 3 options for LTD and/or one of 6 options for STD:

LTD	<input type="checkbox"/> Gold	<input type="checkbox"/> Silver	<input type="checkbox"/> Bronze
STD			
Percentage ¹	<input type="checkbox"/> 1/8/13	<input type="checkbox"/> 1/8/26	<input type="checkbox"/> 15/15/26
Flat Amount ²	<input type="checkbox"/> 1/8/13	<input type="checkbox"/> 1/8/26	<input type="checkbox"/> 15/15/26

¹Percentage: 66.67% of Weekly Salary

²Flat Amount: \$200 per week

Protection Pack - Employer Contributions (25% to 100%): _____%

Protection Pack Option (check one):

- Basic
- Essential
- Enhanced
- Deluxe
- Premium



6. Premium Only Plan...I am applying for P.O.P. administrative services.

Yes No I want to set up a Premium Only Plan (P.O.P.) to be administered by Ceridian (an independent company not affiliated with Anthem Blue Cross and Blue Shield). I have read the P.O.P. brochure and am enclosing my completed P.O.P. enrollment form and separate check for the first year's fee of \$125, along with my application.

7. Eligibility...please tell us more about your group.

- A. How many employees (including owners/officers) work at least 24 hours/week, not including those working on a temporary or substitute basis? _____
- B. How many have met the required probationary/waiting period? _____
- C. How many are enrolling in this employer's group coverage? _____
- D. How many are enrolled in group coverage elsewhere, or have an individual policy? _____
- E. How many work or live outside the state of Colorado? _____
- F. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? Yes No
If yes, please explain what class or number of work hours required (must be at least 24 hours): _____
- G. If you are a Business Group of One, was your prior health coverage Group or Individual? Grp Ind
If Individual:
Please indicate the length of time covered: _____
- H. Please identify the probationary/waiting period for new employees as being the 1st of the month after:
 hire date 1 month 2 months 3 months
 4 months 5 months 6 months
- I. Is your group currently subject to COBRA? (employed 20 or more employees on at least 50% of working days in previous calendar year) Yes No
- J. Is your group subject to State Continuation Coverage? Yes No
- K. Under TEFRA/DEFRA, which one applies to your group?
 Medicare is primary (for groups with fewer than 20 employees)
 Anthem is primary (for groups with more than 20 employees)
- L. How many months are employees eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence (maximum 3 months)?
 none 1 month 2 months 3 months
- M. How many months are employees eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence (maximum 6 months)?
 none 1 month 2 months 3 months
 4 months 5 months 6 months
- N. Is any employee currently **NOT** actively at work? Yes No
- O. To your knowledge, is any person to be covered unable to work due to injury or illness? Yes No
- P. To your knowledge, is any person unable to perform the normal duties of another person in the same employment class of the same age and gender? Yes No
- Q. Provide name(s), date(s) and degree of recovery for any "Yes" answers to Questions O and P:

8. Please tell us if your group has had coverage within 90 days of this application's signature date...

Will this plan replace current:	If yes, the carrier is/was:	Termination date is/was:
Medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Life coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
LTD coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
STD coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____

9. Reserved...please skip this section unless special instructions are provided.



10. Employer Information . . . please read carefully

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Employers with 10 or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates. Employers have the right to see premium quoted either way. The total premium will initially be the same based on the enrollment assumption used to prepare the quote. However, subsequent enrollment changes may result in premium differences depending on the rate method selected. Composite rates use average rates by coverage type, while age rates use the actual rates for each individual in the group based on the age of the employee.

11. General Agreement

The undersigned employer and/or authorized representative hereby request(s) approval for insurance coverage by Anthem and HMO Colorado. Our signature below will indicate that Anthem and/or HMO Colorado are approving coverage. By signing this application, the undersigned employer agrees to be bound by the terms of the contract. The employer agrees that:

1. The requested coverage is not in effect until this application is approved by Anthem and/or HMO Colorado; that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer; and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem and/or HMO Colorado.
2. The advance premium check does not create temporary or interim insurance coverage, and receipt and deposit of that payment does not guarantee issuance of insurance coverage; rather, issuance of insurance coverage is expressly conditioned on Anthem's and/or HMO Colorado's determination that the employer satisfies Anthem and/or HMO Colorado's current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem and /or HMO Colorado, except to refund the advance premium payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
3. For Anthem and/or HMO Colorado, to accept this application, all the information requested on this application must be completed. If the application is not complete, Anthem and/or HMO Colorado or their designated agent(s) are authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem and/or HMO Colorado may be different from the coverage applied for herein. If Anthem and/or HMO Colorado notifies the employer of such different coverage, and the employer pays the appropriate premium, the employer will be deemed to have accepted the coverage as issued.

12. Signatures

Name of Company Officer (Please print)	Title of Company Officer
Signature of Company Officer X	Date (month/day/year)
Accepted by Officer of Anthem Blue Cross and Blue Shield/HMO Colorado	Date (month/day/year)





Final Check

- Please check to make sure all requested information has been provided. Incomplete applications will be returned, which may increase processing time.
- Include a copy of your most recent Quarterly Tax and Wage Statement (or payroll or applicable tax records if you don't file Quarterly Tax and Wage Statements).
 - Indicate on the document whether each employee listed is full-time, part-time or terminated.
 - Write in the names of any newly hired employees (not listed on the document) and the number of their weekly work hours.
 - Send us a copy of your prior carrier bill or bills (if applicable).
 - Include all of the original employee applications.
 - Include a signed proposal for all lines of coverage for which you're applying.
 - If you are applying as a business group of one, please include copies of your most recent business tax return.
- Include a check for the first month's premium, payable to Anthem Blue Cross and Blue Shield.
- If applicable, include a completed P.O.P. enrollment form and a separate check in the amount of \$125 payable to Ceridian.
- Submit all required forms and documentation to your agent or to the address below:
Anthem Blue Cross and Blue Shield
P.O. Box 172466
Denver, CO 80217-2446

Thank you for your time and trust.

For more information online, please visit **[anthem.com](https://www.anthem.com)**.

