

Enrollment Application



Group size 2-50 eligible employees

Group Name: _____

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.

Group Number: _____

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. All information given should apply to this employer.

1. TYPE OF COVERAGE REQUESTED: Employee Only Employee+Spouse Employee+Child(ren) Family Life Only No coverage

2. ENROLLMENT INFORMATION Single Divorced Married

Relationship	Last Name, First Name, M.I.	Social Security No. SSN required for Lumenos, Health Savings Account	Sex	Full Time Student?	Age	Date of birth	Height/Weight	Current tobacco user?	Disabled?
Employee			<input type="checkbox"/> M <input type="checkbox"/> F			/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F			/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Home Address: Street, City, State, ZIP Code _____ County _____

Employee Home Phone () _____ Employee Work Phone () _____ Employee Email Address _____

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) _____ Dependent Name(s) _____

3. MEDICAL INFORMATION (If yes, circle condition)

- Do you or your dependents regularly take medication? Yes No
- Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? Yes No
- Are you or any of your dependents currently pregnant? Yes No
If yes, name _____ due date ____/____/____
- In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor/growth; disorder of the blood or immune system; stroke, aneurysm, high blood pressure, diabetes (list age of onset below); mental/nervous disorder; Parkinson's disease; migraine/cluster headaches; seizures/epilepsy; depression; alcohol or drug abuse/dependency; kidney disease; kidney stones; liver or pancreas disorder; digestive/intestinal disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; muscular dystrophy; infertility/reproductive organ disorder; congenital disease or birth defect; cerebral palsy? Yes No
- In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? Yes No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of Individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of Treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 3 above and in sections 5 through 10 on page 2 and 3 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 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 coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

READ THE TERMS SECTIONS 4 AND 11 CAREFULLY BEFORE SIGNING. PLEASE REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant Signature _____ Please Print Name _____ Date / /

ANTHEM USE ONLY

Coordination of Benefits? Yes No Pre-ex (date) _____

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5. PLEASE COMPLETE ALL INFORMATION

Reason for application: <input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment (N/A for Life coverage) <input type="checkbox"/> Qualifying event (please complete date and reason) Event Date ____/____/____ <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption <input type="checkbox"/> Termed Employment <input type="checkbox"/> Other <input type="checkbox"/> COBRA Event _____ Date ____/____/____ <input type="checkbox"/> State Continuation <input type="checkbox"/> Waiver	Group Name	Group number	Sub Group Number
	Group Address		Employee Hire/Rehire Date (Full time) ____/____/____
	Employee status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (please explain)	Hours working per Week _____ If not actively working, reason _____ _____ Projected Return Date ____/____/____	Occupation _____ Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other (please explain) _____ _____ _____

6. COVERAGE SELECTION (Availability dependent upon your employer's offering)

Medical Coverage Please check one type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	Check the medical plan you are applying for: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> HDHP*	<input type="checkbox"/> HDHP*/PPO <input type="checkbox"/> Core <input type="checkbox"/> Buy Up <input type="checkbox"/> PPO/PPO <input type="checkbox"/> Core <input type="checkbox"/> Buy Up	<input type="checkbox"/> Lumenos [®] Health Savings Account <input type="checkbox"/> Lumenos [®] Health Reimbursement Account <input type="checkbox"/> Lumenos [®] Health Incentive Account	*Do you have, or are you establishing a Health Savings Account? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Coverage: Please check one type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Coverage
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Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.

7. WAIVER OF COVERAGE SECTION: (Must be completed if employee and/or dependents waive medical, dental or life coverage)

NOTE: If waiving coverage, please complete this section. Section 4 must also be signed and dated.

Medical Coverage declined for (check all that apply): <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s)	Reason for Declining Coverage (check all that apply): <input type="checkbox"/> Covered by spouse's group coverage - Carrier name and ID Number _____ <input type="checkbox"/> Enrolled in other Insurance provided by my employer - Carrier name and ID Number _____ <input type="checkbox"/> Enrolled in Individual coverage - Carrier name and ID Number _____ <input type="checkbox"/> Spouse covered by employer's group medical Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Other (Please explain) _____ <input type="checkbox"/> No coverage
Dental Coverage declined for (check all that apply): <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s)	
Life coverage declined for: <input type="checkbox"/> Myself	

8. PRIOR HEALTH INSURANCE INFORMATION

Prior Health Care Coverage During the past 2 years (including Anthem):

Insurance company name(s):	Type of prior coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Family <input type="checkbox"/> Other	Policy number	Effective Date ____/____/____	Cancel Date ____/____/____
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9. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? Yes No

Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date ____/____/____
Policy/Certificate Holder's Name	Social Security Number	Date of birth ____/____/____	Relationship to applicant
Medicare ID #	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset Date ____
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date ____/____/____	Medicare Part D term date ____/____/____

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10. Life and Disability Insurance

<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Dependent Life <input type="checkbox"/> Optional AD&D <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Optional Life: _____ x annual earnings OR \$ _____ <input type="checkbox"/> Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> Anthem By Design Short Term Disability-BUY UP <input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP <input type="checkbox"/> Anthem By Design Basic Life-BUY UP (Complete separate election form)	Life Class
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Primary Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
			- -		
Contingent Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
			- -		

11. SIGNIFICANT TERMS, CONDITIONS AND (UNDERWRITES LIFE AND DISABILITY COVERAGES ONLY) AUTHORIZATIONS (TERMS) *Please read this section carefully before signing the application in Section 4.*

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company (underwrites life and disability coverages only) may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions. (Not applicable to MO HMO products.)
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period (90 days in Kansas) prior to enrollment. This exclusion may last up to 12 months (90 days in Kansas) from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption.
I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of prior creditable coverage from the prior Health Insurance Carrier. (Not applicable to MO HMO products.)
4. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). 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 dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
5. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

Your health coverage will be provided by one of the following companies:

Anthem Blue Cross and Blue Shield is the trade name RightCHOICE Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). RIT, HMO Missouri, Inc., HALIC and ALIC are independent licensees of the Blue Cross and Blue Shield Association.

By signing Section 4, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. **Thank you for choosing Anthem Blue Cross and Blue Shield.**