

Enrollment Application



Group size 2-50 eligible employees

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
- 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

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 Address Employee status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (please explain) _____ _____ _____	Group number _____	Sub Group Number _____	Employee Hire/Rehire Date (Full time) _____ / _____ / _____	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"/> Blue Preferred [®] Plus Hospital Surgical POS <input type="checkbox"/> HDHP* <small>Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.</small>	<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	Vision 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 Coverage <input type="checkbox"/> No coverage
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, vision, 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) Dental Coverage declined for (check all that apply): <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) Vision 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 For WI only: <input type="checkbox"/> I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP). <input type="checkbox"/> My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).			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		
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 _____ / _____ / _____	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	Family members covered by Medicare:	
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"/> Anthem By Design Short Term Disability-BUY UP	Life Class	
<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP		
<input type="checkbox"/> Optional Life: _____ x annual earnings OR \$ _____			<input type="checkbox"/> Anthem By Design Basic Life-BUY UP		
<input type="checkbox"/> Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			(Complete separate election form)		
<i>Primary Beneficiary</i>	Last name	First name, M.I.	Social Security # - -	Relationship to applicant	Age
<i>Contingent Beneficiary</i>	Last name	First name, M.I.	Social Security # - -	Relationship to applicant	Age
11. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application in Section 4.					
<p>1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.</p> <p>2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions.</p> <p>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 prior to enrollment. This exclusion may last up to 12 months 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.</p> <p>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.</p> <p>5. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.</p>					
<p>In Wisconsin: Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWi") and Compcare Health Services Insurance Corporation ("Compcare"). Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies.</p>					
<p>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.</p>					