

# Enrollment Application

We look forward to serving you.

AnthemLife

Anthem. 

**Please complete in ink.** (Read and complete all of this form; if you need more space, attach a separate sheet of paper.  
Please use 4 digits for years (e.g., 1999 not 99).

Reason for application

New enrollment

Changing status (See Section B.)

Reinstatement

Rehire Date of rehire \_\_\_\_\_

Are you a current COBRA participant? If yes, COBRA effective date \_\_\_\_\_

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COBRA qualifying event

Waiving health and life coverage (Complete Sections E, H and J only.)

Waiving life coverage only (Complete all sections EXCEPT Section G.)

Waiving health coverage only (Complete all sections EXCEPT Section D.)

## Section A. Applicant Information

Last name		First name, MI		Social Security Number	
Home address			City, State, ZIP code		
County	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of birth
Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Home telephone (include area code)		Business telephone (include area code)		Occupation
Employer/group name	Hours working per week for this employer	Income reported by <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other	Date of hire as full-time	Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select product/type of health coverage					
<input type="checkbox"/> Anthem HMO (a health insuring corporation product or "HIC")	<input type="checkbox"/> HMP (a HIC product)	<input type="checkbox"/> CMM	<input type="checkbox"/> Basic Life	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Employee
<input type="checkbox"/> Anthem Premier (Select Network)	<input type="checkbox"/> Anthem POS	<input type="checkbox"/> Other	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Employee/spouse
<input type="checkbox"/> Network Series 100	<input type="checkbox"/> Community Choice POS	<input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Dependent Life		<input type="checkbox"/> Employee/child(ren)
<input type="checkbox"/> Network Series 200	<input type="checkbox"/> Anthem PPO	<input type="checkbox"/> Dental*	<input type="checkbox"/> Supplemental Life		<input type="checkbox"/> Employee/spouse/child(ren)
<input type="checkbox"/> Network Series 300	<input type="checkbox"/> Community Choice PPO	<input type="checkbox"/> Vision	<input type="checkbox"/> Supplemental AD&D		
*Please check if coverage for DENTAL is different than selection above.					
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee/spouse	<input type="checkbox"/> Employee/child(ren)	<input type="checkbox"/> Employee/spouse/child(ren)		

## Section B. Status Changes Only

(Complete this Section and sign at end of Section I. When adding dependent(s), also complete sections C, E, F and H (& D if HMO/POS).)

Change is for <input type="checkbox"/> Health only <input type="checkbox"/> Life only <input type="checkbox"/> Health and Life	Date of event	Change coverage to <input type="checkbox"/> Employee only <input type="checkbox"/> Employee/spouse <input type="checkbox"/> Employee/child(ren)	<input type="checkbox"/> Employee/spouse/child(ren)	Change status due to <input type="checkbox"/> Divorce <input type="checkbox"/> Spouse deceased <input type="checkbox"/> Medicare extended	<input type="checkbox"/> Marriage <input type="checkbox"/> Termination of employment
Change last name to	Change address to		<input type="checkbox"/> Delete the following dependents		
<input type="checkbox"/> Adding dependent(s) (List in Section C.)	Reason for addition/deletion	Date of birth/date of adoption or placement for adoption (Attach copy of adoption papers.)			
<input type="checkbox"/> Change primary care provider (Explain reason for change here, and enter new PCP information in Section D below.)					
<input type="checkbox"/> Change of beneficiary for Life	Primary (Include name, age, relationship of beneficiary to insured.)			Contingent (name, age, relationship of beneficiary to insured)	
<input type="checkbox"/> Change in Life insurance classification	From/to			<input type="checkbox"/> Other change (explain)	

## Section C. If applying for other than Employee Only coverage, list spouse and unmarried children below.

(Attach a separate sheet if necessary.)

First, MI, Last Name	SSN	Sex	Age and Date of birth	Relationship to applicant	Height/weight	Eligible for federal income tax exemption?	Court ordered health coverage for child?

**Section C. (continued)**

Is any dependent listed above over age 19 and currently a full-time student (12 or more hours) at an accredited educational institution? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide dependent's name and address, if different than the applicant's address.
Name and address of any other dependent (if different than the applicant's address)	Is any dependent currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, reason	

**Section D. Only complete if applying for HMO or POS coverage options.**

Select a primary care physician (PCP) from the Anthem Provider Directory for yourself and each dependent. A different physician may be selected for you and each person. Make sure the physician(s) you select accepts new patients. (Attach a separate sheet if needed.)

Name	Patient's ZIP code	PCP name	PCP number	New patient for this PCP?
APPLICANT				

**Section E. Prior Health Coverage (Attach a separate sheet if needed.)**

1. Have you previously been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Group name/ID number.
2. Have you and/or your dependents had prior coverage with another carrier(s) within the last 18 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are being added to an existing group, provide Certificate(s) of Prior Health Coverage.
If yes, name of prior insurance carrier(s) and phone number(s)	Policy/certificate number
Effective date	
Is coverage still in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No	if no, termination date
Reason for termination? <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Employment terminated	<input type="checkbox"/> Death of spouse <input type="checkbox"/> Group plan terminated <input type="checkbox"/> COBRA coverage exhausted
<input type="checkbox"/> Employer contribution ceased <input type="checkbox"/> Other	
List any dates when coverage was not in effect.	

**Section F. Other Health Coverage (Attach a separate sheet if needed.)**

On the day your coverage begins, will family members, including those not listed above, be covered by any other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide name, phone number, address of HMO or insurance company.
Name of policy/certificate holder, relationship to applicant	Social Security Number
Date of birth	Policy/certificate number
Type of coverage	Name, address of employer (if this coverage is through an employer group)
If you and/or your spouse/dependent are enrolled in Medicare Part A or B or Medicaid, complete the following. (Attach a separate sheet if needed.)	
1. Enrollee's name	Medicare/Medicaid ID number
Medicare Part A (Hospital) effective date	Medicare Part B (Medical) effective date
Reason for Medicare entitlement <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> ESRD and disability	ESRD onset date
2. Enrollee's name	Medicare/Medicaid ID number
Medicare Part A (Hospital) effective date	Medicare Part B (Medical) effective date
Reason for Medicare entitlement <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> ESRD and disability	ESRD onset date

**Section G. Life Insurance (underwritten by Anthem Life Insurance Company)**

Class (if applicable)	Are you currently actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, reason
Current Income \$ _____ <input type="checkbox"/> Per hour <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Per year	Basic Life <input type="checkbox"/> Yes <input type="checkbox"/> No	Basic Accidental Death and Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No
Supplemental Life <input type="checkbox"/> Yes _____ x annual earnings, or <input type="checkbox"/> No \$ _____	Supplemental AD&D <input type="checkbox"/> Yes _____ x annual earnings, or <input type="checkbox"/> No \$ _____	Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No
Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
1. Primary beneficiary (Last, first name, MI, relationship to insured, age)		
2. Contingent beneficiary (Last, first name, MI, relationship to insured, age)		

**Section H. Medical Information**

Groups with 21 or more eligible members, please complete Part 1. If there are any "Yes" answers in Part 1, please also complete Part 2. Groups with 20 or fewer eligible members, please complete Parts 1 and 2. **Please note that no person will be denied health coverage on an individual basis due to the answers provided below.**

**Part 1.**

- 1. Do you or any of your dependents regularly take medication (prescription or other)?  Yes  No
- 2. Has a physician told you or any of your dependents that surgery or special medical tests or treatment might be required or necessary at some future date?  Yes  No
- 3. Are you or any of your dependents currently pregnant?  Yes  No  
If yes, name \_\_\_\_\_ Due date \_\_\_\_\_
- 4. In the last 5 years, have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer; stroke; diabetes (list type below including age of onset and treatment); mental or nervous disorder; depression; kidney, liver or pancreas disorder; emphysema; ulcerative colitis; Crohn's disease; aneurysm; lupus; lung disorder or Chronic Obstructive Pulmonary Disorder (COPD); or rheumatoid arthritis?  Yes  No
- 5. In the last 5 years, have you or any of your dependents been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?  Yes  No

**Part 2.**

- 1. To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
  - a. Leukemia, tumor, growths or any diseases of the skin?  Yes  No
  - b. Ulcers, stomach disorders, hernia, hemorrhoids, diverticulitis, rectal disorder, irritable bowel syndrome or other intestinal disorder?  Yes  No
  - c. Thyroid, goiter, gallbladder or prostate disorder? Disorder of the blood or immune system?  Yes  No
  - d. High blood pressure, elevated cholesterol or triglycerides?  Yes  No
  - e. Heart attack, angina, heart murmur, anemia, chest pain or any disorder of the heart, arteries, veins or circulatory system?  Yes  No
  - f. Arthritis, gout, polio, rheumatic fever, multiple sclerosis, muscular dystrophy, carpal tunnel syndrome, disorder of the muscles, back or joints?  Yes  No
  - g. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system?  Yes  No
  - h. Bronchitis, asthma, sinus or nasal disorder, allergies, pneumonia, or any other disorder of the lungs or respiratory system?  Yes  No
  - i. Alcoholism, drug abuse, or attended alcohol or drug dependency organization meetings, or been convicted of DUI/DWI?  Yes  No
  - j. Any sexually transmitted diseases or disorder of the genital, reproductive or urinary system?  Yes  No
  - k. Any disorder of the eyes, ears, nose or throat?  Yes  No
- 2. Have you or any of your dependents had an inpatient admission or outpatient surgery, medical or surgical advice, or a condition not identified above, during the past 5 years?  Yes  No
- 3. Have you or any of your dependents, within the last two years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane, or are any such activities contemplated?  Yes  No
- 4. Have you or any of your dependents used tobacco products (including cigarettes) in the last 12 months?  Yes  No
- 5. Are you or any of your dependents presently disabled or unable to perform their duties?  Yes  No

Explain "Yes" answers to any question in Section H. Give complete details. Use extra paper if necessary.

Question No.	Name of individual	Diagnosis, treatment	Date(s) of treatment, length of hospital stay, degree of recovery. Health provider's name, address, phone number.

**Section I. Read carefully before signing. Please review your application for errors or omissions.**

An eligible claim may not be paid if omissions or errors relating to the claim are found on this application. If dependent or other coverage information changes at any time while your coverage is in effect, you must complete a new application form.

- 1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself or for any dependents listed herein, by any provider of health services to Community Insurance Company dba Anthem Blue Cross and Blue Shield, and/or Anthem Life Insurance Company (hereinafter collectively "Anthem" unless otherwise specified) its subsidiaries, affiliates, and any administrators, reinsurers, agents or other entity providing services on behalf of Anthem. This information will be used for purposes which include but are not limited to: processing this application for enrollment, group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; case management; quality improvement programs, reviews and audits; public health reporting; health care research; peer review; utilization review; coordination of benefits; subrogation; health promotion, disease management/prevention, and any other managed care/prevention program. I understand that Anthem may furnish this information to the group or its representative. Anthem may also furnish information to other entities, which may include but is not limited to, third party administrators, pharmacy benefit managers, insurers; and to government agencies. Anthem will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but 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. *I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my authorization. I also understand that under 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 this law by writing to Anthem.*
- 2. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
- 3. I authorize deduction from my wages if necessary for the required premium for the coverage for which I have applied.
- 4. I am applying for the coverage selected on this application. If I select a coverage, or 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 reserves the right to accept or decline this application (and that Anthem Life may accept only certain persons or conditions for coverage) in accordance with Ohio law and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions (unless I applied for HIC/HMO coverage, in which case there is no such exclusion).
- 6. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
- 7. 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.

(continued on next page)

**Section I. (continued)**

I acknowledge that I have read the foregoing provisions and I accept such provisions 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 a 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). By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself. This authorization, for purposes of processing this application form, is valid from the date signed for a period of two and one-half years. A photocopy is as valid as the original. I understand I may request a photocopy. 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 give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Employee signature

Date

**Section J. Waiver of coverage.**

Check the box next to coverage(s) waived.

Employee name

Social Security Number

Employer name

I am already protected by the coverage of my  Spouse  Parent  None

Through his/her place of employment (give name)

Whose carrier is  Anthem Blue Cross and Blue Shield (Give certificate/policy number)  Other carrier (Give name, ID number)

I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such service hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees (and the plan permits late enrollment). 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 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 my dependent(s) nor I 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.

Signature of person(s) waiving

Date