Anthem Blue Cross
Large Group Member Enrollment/Change Form

Anthem HealthChoice HMO, Inc. and/or Anthem HealthChoice Assurance, Inc. underwrite medical, dental, vision, group accident, specified disease and hospital indemnity insurance products.

Thank you for choosing Anthem Blue Cross (Anthem).

So that we may quickly and accurately process your enrollment, please complete in full and sign in section 7.

Section 1: Reason for enrollment/change — Please complete section A, B or C.

A. New enrollment/addition — Choose only one reason in bold.

☐ **New hire** — Must indicate start date of full–time employment in section 8. Leave ***Date of change*** field blank. **Date of change:** ____ (MMDDYY)

☐ **Open enrollment** — Leave ***Date of change*** field blank.

☐ **Status change** — Select only one.

☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement ☐ Medicare eligible For ***Medicare eligible*** only, answer the following questions:

Eligibility criteria — Select only one . . . . . ☐ Age 65+ ☐ Disability ☐ ESRD: Onset date: ____ (MMDDYY)

Active employee? . . . . . ☐ Yes ☐ No

Electing company coverage as primary coverage? . . . . . ☐ Yes ☐ No

Electing Medicare-related coverage as primary coverage? . ☐ Yes ☐ No

(If company size is under 20 employees and end-stage renal disease does not apply, you must choose this option)

☐ **Age 29 Adult Dependent Election** — Must complete section 4.

☐ **Original COBRA/NYS Continuation of coverage:** ____ (MMDDYY)

Nature of COBRA/NYS event: _____

☐ **Loss of Coverage** — Must indicate last day covered in section 6.

You must fill out the following section: Would you like to be added to the Donate Life Registry? ☐ YES or ☐ SKIP THIS QUESTION

B. Change — Check all that apply. For all checked boxes below, please supply new information in sections 4 and 5.

☐ Name ☐ Primary Care Physician (PCP) (POS plans only) Date of change: ____ (MMDDYY)

☐ Address ☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Anthem Dental plan)

C. Cancel coverage — Select only one.

Note: If you are canceling your own coverage, please have your employer fill out a *Member Maintenance Change Form*. For other cancellations, please check the appropriate box below and enter the name in the Applicant and Family portion in section 5.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible Date of event: ____ (MMDDYY)

☐ Other: _____

Section 2: Benefits Selection

Medical insurance — Select only one plan type.

Large group plans (101+ eligibles)

Product/Plan: ☐ PPO ☐ EPO

Network: ☐ PPO/EPO Network ☐ Blue Access Network ☐ Connection Network (EPO Only)

Gatekeeper (EPO Only): ☐ Yes ☐ No ☐ N/A

Reimbursement Account: ☐ HSA ☐ HRA

Other: _____

Select only one medical coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Dental insurance

☐ Anthem Dental Prime
☐ Anthem Dental Complete
☐ Anthem Dental Premium Care (PPO)
☐ Anthem Dental XPO
☐ Anthem Dental Consumer Choice PPO
☐ Anthem Dental Essential Choice PPO
☐ Anthem Dental Essential Care (managed care)
☐ Anthem Dental Enhanced Care PLUS (managed care)
☐ Anthem Dental Enhanced Care (managed care)
☐ Anthem Dental Comprehensive Care (managed care)

Select only one dental coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Vision insurance

Blue View Vision℠ Select only one vision coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Flexible Spending Account (FSA)

☐ Healthcare FSA (excluded if you have an HSA plan) ☐ Limited-Purpose FSA for dental and vision services only (with an HSA plan)

Section 3: Group Accident, Specified Disease, and Hospital Indemnity Insurance

☐ Group Accident Insurance — Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ Group Specified Disease Insurance — Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Specified Disease plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: ____________________

☐ Group Hospital Indemnity Insurance — Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Specified Disease or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy or an employer sponsored health plan that provides essential health benefits? ☐ No ☐ Yes (Please note that if the response is No, such applicants are not eligible for coverage)

Will all applicants who reside in NY, when such coverage is to become effective, be enrolled under or have another application(s) pending for any other specified disease policy that is not being replaced in full by this coverage? **(Please note that if the response is Yes, such applicants may not be eligible for coverage)** ☐ No ☐ Yes

Applicants residing in NY: As of the date of this application, total number of specified diseases for which all applicants have specified disease coverage in force or have another application(s) pending for any other specified disease policy: Employee: ______ Spouse: ______ Child(ren): ______

List specific specified diseases for which all applicants have specified disease coverage in force or have another application(s) pending for any other specified disease policy (list applicable conditions):

Employee: ____________________

Spouse: ____________________

Child(ren): ____________________

Beneficiary designation — Attach a separate sheet if necessary.

Beneficiary type	Name of beneficiary	Percentage	Social Security no.*	Relationship to applicant		Date of birth
☐ Primary ☐ Contingent		%				
	Street address	City		State	ZIP code	Phone no.
Beneficiary type	Name of beneficiary	Percentage	Social Security no.*	Relationship to applicant		Date of birth
☐ Primary ☐ Contingent		%				
	Street address	City		State	ZIP code	Phone no.
Beneficiary type	Name of beneficiary	Percentage	Social Security no.*	Relationship to applicant		Date of birth
☐ Primary ☐ Contingent		%				
	Street address	City		State	ZIP code	Phone no.
Beneficiary type	Name of beneficiary	Percentage	Social Security no.*	Relationship to applicant		Date of birth
☐ Primary ☐ Contingent		%				
	Street address	City		State	ZIP code	Phone no.

Total percentages must add up to 100%. If the total percentages add to up less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add to up more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Section 4: Applicant information

Last name	First name	M.I.	Social Security no.[1] (required)

Gender ☐ Male ☐ Female ☐ Gender X	Date of birth (MMDDYY)	Marital status ☐ Single ☐ Married	Marriage date (MMDDYY)	Primary phone no.

Street address	Apt. no.

City	State	ZIP code

Occupation	Primary language

Email address

I'm providing my email address because I want to receive information about my benefits electronically. These communications may include Identification (ID) Cards, Contracts or Certificates of Coverage, billing invoices, Explanation of Benefits, required notices including cancellations and renewals, and helpful or specific personalized information to help get the most out of the benefits. I understand I need to register on **anthembluecross.com** or the Anthem mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up to date email address. I understand that I can update my email address, communication preferences, and request free copies of any materials by going to **anthembluecross.com** or calling the Member Services number on my ID card.

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Section 5: Family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets, if necessary.

To select a PCP and/or PCD, visit our website at **anthembluecross.com** and select **Find Care**. If your Anthem benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Applicant

Primary care physician (PCP) last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

Primary care dentist (PCD) last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

☐ Spouse ☐ Domestic partner

Last name	First name	M.I.	Social Security no.[1] (required)

Gender ☐ Male ☐ Female ☐ Gender X	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Anthem is required by the Internal Revenue Service to collect this information.

Section 5: Family information — Continued.

Dependent 1

Last name	First name	M.I.	Social Security no.[1] (required)

Gender ☐ Male ☐ Female ☐ Gender X	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 2

Last name	First name	M.I.	Social Security no.[1] (required)

Gender ☐ Male ☐ Female ☐ Gender X	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 3

Last name	First name	M.I.	Social Security no.[1] (required)

Gender ☐ Male ☐ Female ☐ Gender X	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 4

Last name	First name	M.I.	Social Security no.[1] (required)

Gender ☐ Male ☐ Female ☐ Gender X	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 6: Other medical coverage information — This section must be completed.
The questions in this section are for informational purposes only. The answers provided will have no bearing on eligibility.

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No **If yes, please complete the following:**

Name(s) of person(s) (first, M.I., last)	Insurance company name	Coverage dates	Provided by employer?	Employment status	Contract type
Self	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Carrier name Policyholder name Phone Certificate (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

Prior and other dental coverage information

Has any person applying for coverage had prior or other dental insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Carrier name: _____ Carrier phone no.: _____ Member ID: _____

Date coverage began: ____ ____ ____ Date ended: ____ ____ ____ (MMDDYY)

Included orthodontia? ☐ Yes ☐ No

Section 7: Terms, Conditions and Authorizations

Please read this section and the Insurance Fraud Statement below carefully before signing the application.

I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group's contract(s). I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent's, status; such change may result in a change of insurance status with Anthem and that failure to make such notification may result in cancellation of the coverage by either carrier, subject to the incontestability clause of the contract.

I understand that if I become Medicare eligible while I am covered under the medical contract, any benefits I am entitled to under that contract will be reduced by the amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare.

If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, the insurers shall notify the employer of such differences, and seek the enrollees written consent to issue the different coverage.

All statements and answers in this notice of election are true and complete to the best of my knowledge and belief. Any material misrepresentation may result in Anthem's cancellation of coverage which may result in an otherwise valid claim being denied subject to any applicable incontestability clause.

I certify each Social Security number submitted is correct.

Insurance Fraud Statement: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact there to, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim or each such violation.

Applicant signature	Print name	Date (MMDDYY)
X		

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

This is ACCIDENT insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage. This policy only pays benefits related to a covered accident. IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Important Specified Disease Insurance eligibility information:

The following notice(s) apply to all Specified Disease and Voluntary Specified Disease coverage presented on this form:

SPECIFIED DISEASE insurance is a supplement to health insurance and is NOT a substitute for major medical coverage. This is not a qualifying health coverage ("minimum essential coverage") that satisfies the health coverage requirement of the affordable care act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

This is HOSPITAL INDEMNITY insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage. It pays a fixed dollar amount for covered benefits without regard to the health care provider's actual charges. The benefit payments are not intended to cover the cost of your medical care. These benefits are paid in addition to any other health insurance coverage you may have.

Section 8: Employer information — This section must be filled in by your group benefits administrator.

Group name		Group no.	Group sub no.
Street address	City	State	ZIP code
Employee no.	Payroll/Department location		Applicant's full-time employment start date
Authorized Group Benefits Administrator signature X	Print name		Date (MMDDYY)