Employee Enrollment Application

Anthem.
Anthem Health Plans of Kentucky, Inc.

Anthem Life
Anthem Life Insurance Co.

Group size 100+ eligible employees

Your Anthem enrollment application is inside. It is essential that you read it carefully and complete all the necessary sections.

If you are a new enrollee:

a) applying for health, vision and/or dental coverage plus life and disability insurance, please complete sections 2, 4, 5, 6, 7, 8, 9, and 10. Your signature is required in Section 10.

b) applying for health, vision and/or dental coverage but waiving life and disability insurance, please complete sections 2, 4, 5, 6, 8, 9, 10, and 11. Your signature is required in Section 10.

c) applying for life and disability insurance but waiving health coverage, please complete sections 2, 5, 6, 7, 10 and 11. Your signature is required in Section 10.

d) waiving all coverage, please complete sections 2, 5, and 11. Your signature is required in Section 11.

If you are adding a dependent(s),
complete section 3 in addition to the above.

If you are a new enrollee in Anthem ByDesign Buy-up Coverage:

Applying for Anthem ByDesign Buy-up Health, Dental or Vision coverage, please complete the appropriate PPO check box under section 4 "Type of Coverage/Plan" and write in the Health, Dental or Vision plan number of the benefit you have selected on the line provided next to the PPO check box.

Applying for Anthem ByDesign Buy-up Short Term Disability (STD) or Long Term Disability (LTD) coverage, please complete the STD or LTD check box under section 7 "Life and Disability Insurance" and write in the benefit percentage you have selected on the line provided next to STD or LTD.

It is important that you read and understand the Significant Terms, Conditions and Authorizations in Section 10.

***Note:** You may be required to supply additional information.*

Thanks for choosing Anthem Blue Cross and Blue Shield.

www.anthem.com

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd, Louisville, KY 40223
Anthem Life Insurance Company: 6740 N. High Street, Suite 200, Worthington, OH 43085

Enrollment Application

Group size 100+ eligible employees

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Anthem Life Anthem Life Insurance Co.

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com

1. Employer/Group Use:
Employer Name and Address:

Group #	Sub-group #/Life Division #	Request Effective Date	Life Classification	Applicant #/Dept. name
		/ /		

Anthem use: Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	/ /	☐Yes ☐No	☐Yes ☐No	/ /

2. Reason for Application

- ☐ New enrollment
- ☐ Annual open enrollment (N/A to Life)
- ☐ COBRA
  Qualifying event _____ Event date __/__/__
- ☐ Waiver
- ☐ New hire
- ☐ Rehire (date) __/__/__
- ☐ Add dependent (see section 3)

3. Status Change/Event

Event date __/__/__
- ☐ Marriage
- ☐ Birth
- ☐ Adoption*
- ☐ Legal Guardianship*
- ☐ Other _____

**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage	*Dental Coverage*	*Vision Coverage*	*Life Coverage*
☐ HMO* ☐ POS* ☐ PPO ☐ Anthem Essential℠ PPO ☐ Blue Traditional® ☐ Blue Access℠ Hospital Surgical PPO ☐ Lumenos® Health Savings Account ☐ Lumenos® Health Reimbursement Account ☐ Lumenos® Health Incentive Account ☐ Lumenos® Health Incentive Account Plus ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.	☐ PPO ☐ Dental Blue® ☐ Dental Blue® 100 ☐ Dental Blue® 100/200/300 ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage	☐ Vision ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage	☐ Life (see section 7)

5. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth / /	Age	Sex ☐M ☐F	Social Security # (required) - -	☐ Single ☐ Divorced ☐ Married	Height	Weight

Home address	City	State	Zip code	County (KY residents include Municipality)

Home telephone ( )	Business telephone ( )	eMail Address

Are you: Retired? ☐Yes ☐No	Disabled? ☐Yes ☐No	Hospitalized? ☐Yes ☐No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ☐ W2 ☐ 1099 ☐ Other: _____

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐Yes ☐No

6. Family Information **Spouse and dependents to be covered (Attach a separate sheet if necessary)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

*** Please read the Genetic Information Non-discrimination Act (GINA) information on page 3, under Significant Terms, Conditions and Authorizations section , prior to answering the below questions.**

1 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐Yes ☐No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐M ☐F	Social Security # (required for spouse/domestic partner) - -	Height	Weight	Eligible for federal income tax exemption? ☐Yes ☐No Court ordered health care coverage? ☐Yes ☐No (If yes, include legal documentation) Currently hospitalized or disabled? ☐Yes ☐No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐Yes ☐No

2 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐Yes ☐No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐M ☐F	Social Security # - -	Height	Weight	Eligible for federal income tax exemption? ☐Yes ☐No Court ordered health care coverage? ☐Yes ☐No (If yes, include legal documentation) Currently hospitalized or disabled? ☐Yes ☐No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐Yes ☐No

NAME _____ SSN _____

3 Last name	First name, M.I.	Relationship ☐ Spouse ☐ Son to applicant ☐ Daughter ☐ Other _____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

7. Life and Disability Insurance

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability_____%
☐ Dependent Life ☐ Supplemental AD&D ☐ Long Term Disability_____%
☐ Supplemental Life: _____ x annual earnings OR $ _____
☐ Current Income: $ _____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

☐ Anthem By Design® Short Term Disability-BUY UP
☐ Anthem By Design® Long Term Disability-BUY UP
☐ Anthem By Design® Basic Life-BUY UP
(Complete separate election form)

Life Class
Are you currently active at work? ☐ Yes ☐ No
If no, reason: _____

	Last name	First name, M.I.	Social Security # - -	Relationship to applicant	Age
Primary Beneficiary					
Contingent Beneficiary					

8. Other Health Coverage ***Please check one:*** ☐ *YES (completed below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company	Policy/certificate number	Effective date / /

Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID#	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /	

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

9. Prior Health Coverage ***Please check one:*** ☐ *YES (completed below.)* ☐ *NO*

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:	Group name/ID#	Dates Policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	List prior carrier(s)	Dates Policy in effect: / / — / /

Please check the type of prior coverage ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

Significant Terms, Conditions and Authorizations (TERMS) *Please read this section carefully before signing the application.*

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian,* the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. 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.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) 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.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.

NAME ______________________ SSN ______________

6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, 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 Anthem 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).

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, 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.

Applicant Signature	Date / /

11. Waiver of coverage for employee and / or any eligible dependent not enrolling

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)

Check all that apply

☐ 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 coverage 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. 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 dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program)

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I certify that I have been given an opportunity to apply for the available group life benefits offered by my employer/group, 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/group, 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.

Applicant Signature	Date / /