

Anthem Enrollment Application



Group

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 and / or dental coverage plus life insurance, please complete sections 1, 2 and 4 through 11.
- b) applying for life insurance but waiving health coverage, please complete sections 1, 2, 4, 5, 7, 11 and 12.
- c) waiving any or all coverage, please complete sections 1, 2, 5, and 12.

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

It is important that you read and understand the Significant Terms, Conditions and Authorizations on the last page.

Your signature is required on the last page.

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



www.ISMAnet.org

***Thanks for choosing Anthem
Blue Cross and Blue Shield.***

www.anthem.com

Enrollment Application



Group

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
To search for *Blue AccessSM PPO Providers*, visit www.anthem.com

1. Employer/Group use: Employer Name and Address:								
Group #	Sub-group # / Life Division #	Request. Effective Date		Life Classification				
		/ /						
Anthem use:	Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
		/ /	/ /	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

2. Reason for Application <input type="checkbox"/> New enrollment <input type="checkbox"/> Waiver <input type="checkbox"/> Annual open enrollment (N/A to life) <input type="checkbox"/> COBRA Qualifying event _____ Event date ____/____/____		<input type="checkbox"/> New hire <input type="checkbox"/> Rehire (date) ____/____/____ <input type="checkbox"/> Add dependent (see section 3)		4. Type of Coverage/Plan Health Coverage <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		Dental Coverage <input type="checkbox"/> PPO _____	Life Coverage <input type="checkbox"/> Life (see section 7)
3. Status Change/Event Event date ____/____/____ <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> Legal Guardianship* <input type="checkbox"/> Other _____ *Include legal documentation.		Medical Plan Name _____					

5. Employee Information										
Last name		First name, M.I.		Date of birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security #	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	Height	Weight
Home address		City		State	ZIP code	County (KY residents include Municipality)				
Home telephone () -		Business telephone () -		eMail Address						
Are you:	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation		Full time hire date	Hours working per week	Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____		

6. Family Information <i>Spouse and dependents to be covered. (Attach a separate sheet if necessary.)</i>									
1 Last name		First name, M.I.		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____			Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)									
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Height	Weight	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				
2 Last name		First name, M.I.		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____			Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)									
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Height	Weight	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				
3 Last name		First name, M.I.		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____			Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)									
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Height	Weight	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				

7. Life and Disability Insurance <i>*Please complete Primary and Contingent Beneficiary Information in its entirety.</i>									
<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year					Are you currently actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason: _____				
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

8. Other Health Coverage *Please check one:* YES (complete 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 Part A 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 / /

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

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

Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

10. Medical Information *Group size 2-19, eligible employees complete in full. Group size 20-50, eligible employees complete questions 1-5. Group size 51+, skip this section.*
Please note that no person will be denied health coverage on an individual basis due to the answers provided below, except for Medicare Carve-Out.

(If yes, circle condition)

<p>1. Do you or your dependents regularly take medication?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you or any of your dependents currently pregnant?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If yes, name _____ due date / /</p> <p>4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes (list age of onset below); mental/nervous disorder, depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you or your dependents used tobacco products in the last 12 months?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><i>(If yes, circle condition)</i></p> <p>8. 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:</p> <p>a. Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Thyroid, goiter or gallbladder disorder?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. High blood pressure, cholesterol or triglycerides?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Anemia, chest pain, heart murmur or disorder of the veins/circulatory system?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system? ...<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Asthma, allergies, sinus, or disorder of the respiratory system?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Any STD or disorder of the prostate, genital, reproductive or urinary system?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Any disorder of the skin, ears, or eyes?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you or any of your dependents, within the last 2 years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years?<input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				

Please read the TERMS on the reverse side of this page. Your Signature is required on the reverse side of this to submit this application.

Significant terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
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. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
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).

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

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

11. 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 / /

12. Waiver of coverage for employee and / or any eligible dependent not enrolling	
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply	
<input type="checkbox"/> 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.	
<input type="checkbox"/> I certify that I have been given the 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 / /