

Employee Change Form Application



Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections.

Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing www.anthem.com. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

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|---|-------------------------------|------------------------|---------------------|-----------------------|-----------------------|-----|------------------------|--|--|
| 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) | |
| | | / / | / / | / / | / / | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No / / |

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| 2. Reason for Change Event date / / <input type="checkbox"/> Address <input type="checkbox"/> Change Life Beneficiary <input type="checkbox"/> Change Life Classification <input type="checkbox"/> Enrollment in Medicare (see section 7) <input type="checkbox"/> Cancel/Waiving Coverage (Refer to section 9) <input type="checkbox"/> Conversion <input type="checkbox"/> Benefit change <input type="checkbox"/> Cancel dependent <input type="checkbox"/> PCP change <input type="checkbox"/> Name change <input type="checkbox"/> Other _____ | 3. Type of Coverage/Plan Health Coverage <input type="checkbox"/> HMO* <input type="checkbox"/> POS* <input type="checkbox"/> PPO _____ <input type="checkbox"/> Blue Preferred, Plus Hospital Surgical POS <input type="checkbox"/> Lumenos, Health Savings Account <input type="checkbox"/> Lumenos, Health Reimbursement Account <input type="checkbox"/> Lumenos, Health Incentive Account <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 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer. | Dental Coverage <input type="checkbox"/> PPO _____ <input type="checkbox"/> DentaCare (HMO) <input type="checkbox"/> Dental Blue <input type="checkbox"/> Dental Blue Choice 100 <input type="checkbox"/> Dental Blue Choice 300 <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 | Vision 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 | Life Coverage <input type="checkbox"/> Life (see section 7) |
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| 4. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. | | (SS# required for Lumenos, Health Savings Account) | |
| Last name | First name, M.I. | Date of birth / / | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Home address | | City | State |
| Hours worked per week | Anthem PCP name and address* | Zip code | County |
| | | Anthem PCP ID number* | New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If PCP is a change, please indicate the reason for the change. | | | |

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| 5. Family Information Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.) * Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. | | | |
| 1 <input type="checkbox"/> Change <input type="checkbox"/> Cancel | Last name | First name, M.I. | |
| Date of birth / / | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Social Security # | Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____ |
| Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address) | | | |
| Anthem PCP name and address* | | Anthem PCP ID number* | New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If PCP is a change, please indicate the reason for the change. | | | |

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| 2 <input type="checkbox"/> Change <input type="checkbox"/> Cancel | Last name | First name, M.I. | |
| Date of birth / / | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Social Security # | Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____ |
| Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address) | | | |
| Anthem PCP name and address* | | Anthem PCP ID number* | New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If PCP is a change, please indicate the reason for the change. | | | |

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|--|---|-----------------------|---|
| 3 <input type="checkbox"/> Change <input type="checkbox"/> Cancel | Last name | First name, M.I. | |
| Date of birth / / | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Social Security # | Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____ |
| Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address) | | | |
| Anthem PCP name and address* | | Anthem PCP ID number* | New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If PCP is a change, please indicate the reason for the change. | | | |

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| 6. 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 |
| <input type="checkbox"/> Dependent Life | <input type="checkbox"/> Supplemental AD&D | <input type="checkbox"/> Long Term Disability _____ % | <input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP |
| Supplemental Life: _____ x annual earnings OR \$ | | <input type="checkbox"/> Anthem By Design Basic Life-BUY UP | |
| Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year | | (Complete separate election form) | |
| | | | 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 # |
| Contingent Beneficiary | Last name | First name, M.I. | Social Security # |
| | | | Relationship to applicant |
| | | | Age |

Signature required on the reverse side of this form.

7. 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.

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|--|-------------------------------|---------------------------|---------------------------|
| 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.

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|---------------------|-------------------------|---------------------------------------|---------------------------------------|------------------------|
| 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)

8. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

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| <ol style="list-style-type: none"> I may not assign any payment under my Anthem Blue Cross and Blue Shield program. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied. 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. 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. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself. | <p>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).</p> <p>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.</p> |
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Applicant Signature _____ Date / /

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

Check all that apply. Waiving: Health Dental Vision Life All

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|------------------------|---|
| Name of person waiving | Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None |
| Employer name | Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #) |

Check all that apply. Waiving: Health Dental Vision Life All

| | |
|------------------------|---|
| Name of person waiving | Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None |
| Employer name | Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #) |

Check all that apply. Waiving: Health Dental Vision Life All

| | |
|------------------------|---|
| Name of person waiving | Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None |
| Employer name | Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #) |

Check all that apply. Waiving: Health Dental Vision Life All

| | |
|------------------------|---|
| Name of person waiving | Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None |
| Employer name | Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #) |

Check all that apply

I represent 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 represent 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.

Please check if any of the following apply: (WI only)

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).

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).

Other:

Applicant signature _____ Date / /

Life and disability products are underwritten by Anthem Life Insurance Company.
 In Wisconsin, Blue Cross Blue Shield of Wisconsin ("BCBSWI") underwrites or administers the PPO and indemnity policies;
 Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWI collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.