

Employee Enrollment Application



Group size 51+ 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, 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, 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 or Dental coverage, please complete the appropriate PPO check box under section 4 "Type of Coverage/Plan" and write in the Health or Dental 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.**

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

www.anthem.com

Note: You may be required to supply
additional information.

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 and symbols are registered marks of the Blue Cross Blue Shield Association.

Enrollment Application



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Please complete in blue or black 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)			
	/ /	/ /	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /			
2. Reason for Application					3. Status Change/Event					
<input type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment (N/A to Life) <input type="checkbox"/> COBRA Qualifying event _____ Event date ___/___/___					<input type="checkbox"/> Waiver (See Section 11) <input type="checkbox"/> New hire <input type="checkbox"/> Rehire (date) ___/___/___ <input type="checkbox"/> Add dependent (see section 3)					
					Event date ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Birth *Include legal documentation.					
					<input type="checkbox"/> Adoption* <input type="checkbox"/> Legal Guardianship* <input type="checkbox"/> Termed Employment <input type="checkbox"/> Other _____					
4. Type of Coverage/Plan										
Health Coverage			Dental Coverage			Vision Coverage		Life 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.			<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			<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		<input type="checkbox"/> Life (see section 7)		
5. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in Medical or Dental HMO or POS.										
Last name		First name, M.I.		Date of birth	Age	Sex	Social Security # (SS# required for Lumenos, Health Savings Account)	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	Height	Weight
				/ /		<input type="checkbox"/> M <input type="checkbox"/> F	- -			
Home address			City	State	Zip code	County				
Home telephone ()			Business telephone ()			eMail Address				
Are you Retired?	Disabled?	Hospitalized?	Occupation			Full time hire date	Hours working per week	Income reported by:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				/ /		<input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____		
Anthem PCP name and address*						Anthem PCP ID number*		New patient?*		
								<input type="checkbox"/> Yes <input type="checkbox"/> 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.										
1 Last name		First name, M.I.			Relationship to applicant			Fulltime student?		
					<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____			<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	Social Security #	Height	Weight	Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)					
/ /	<input type="checkbox"/> M <input type="checkbox"/> F	- -			Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)					
Anthem PCP name and address*						Anthem PCP ID number*		New patient?*		
								<input type="checkbox"/> Yes <input type="checkbox"/> No		
2 Last name		First name, M.I.			Relationship to applicant			Fulltime student?		
					<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____			<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	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)
Anthem PCP name and address*			Anthem PCP ID number*		New patient?*
					<input type="checkbox"/> Yes <input type="checkbox"/> No
3 Last name		First name, M.I.		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son to applicant <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	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)
Anthem PCP name and address*			Anthem PCP ID number*		New patient?*
					<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Life and Disability Insurance					
<input type="checkbox"/> Basic Life		<input type="checkbox"/> Basic AD&D		<input type="checkbox"/> Short Term Disability	
<input type="checkbox"/> Dependent Life		<input type="checkbox"/> Optional AD&D		<input type="checkbox"/> Long Term Disability	
<input type="checkbox"/> Optional Life: _____ x annual earnings OR \$ _____				<input type="checkbox"/> Anthem By Design Short Term Disability-BUY UP	
<input type="checkbox"/> Current Income: \$ _____		<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		<input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP	
				<input type="checkbox"/> Anthem By Design Basic Life-BUY UP	
				(Complete separate election form)	
<i>Primary Beneficiary</i>	Last name	First name, M.I.		Social Security #	Relationship to applicant
				- -	
<i>Contingent Beneficiary</i>	Last name	First name, M.I.		Social Security #	Relationship to applicant
				- -	
8. Other Health Coverage Please check one: <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> 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:					
<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD & Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)					
9. Prior Health Coverage Please check one: <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> NO					
Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No		Group name/ID#		Date policy in effect:	
Policy/Certificate #:				/ / - / /	
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					
<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)					
Termination reason: <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of spouse <input type="checkbox"/> COBRA coverage exhausted <input type="checkbox"/> Employment terminated <input type="checkbox"/> Group plan terminated					
<input type="checkbox"/> Employer/group contribution ceased <input type="checkbox"/> Other:					

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- 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. more detailed description of my rights under these laws by writing to Anthem.

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), 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.

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.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section on page 3 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: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <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
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"/> Vision <input type="checkbox"/> Life <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
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"/> Vision <input type="checkbox"/> Life <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
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"/> Vision <input type="checkbox"/> Life <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
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 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.	
<input type="checkbox"/> I represent 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.	
Please check if any of the following apply: (WI only)	
<input type="checkbox"/> 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).	
<input type="checkbox"/> 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).	
<input type="checkbox"/> Other:	
Applicant Signature	Date / /