Enrollment Application
Anthem Balanced Funding

Anthem

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. All information given should apply to this employer.

Section 1: Type of coverage requested

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Plan name selected: PPO

Reason for application

☐ New enrollment ☐ Add ☐ Change
☐ Open enrollment ☐ Cancel
☐ COBRA Event: _____
Date: ___/___/___ (MM/DD/YY)
☐ Waive

Qualifying event—please complete date and reason.
Event date: ___/___/___ (MM/DD/YY)
☐ Marriage ☐ Divorce ☐ Birth of child ☐ Adoption ☐ Terminated employment
☐ Other: _____

Section 2: Group information

Group name		Group no.	Subgroup no.
VANDERBURGH COUNTY		W12948M001	
Group street address	**City**	**State / ZIP code**	**Full-time hire/rehire date**
1 NW M L KING JR BLVD	EVANSVILLE	IN 47708	
Employee status	**Hours working per week**	**Occupation**	**Income reported by**
☐ Active ☐ Disabled ☐ Retired ☐ Other: _____			☐ W-2 ☐ 1099 ☐ Other: _____
If not actively at work, reason			**Projected return date**

Section 3: Enrollment information

☐ Single ☐ Married ☐ Divorced

Relationship	Last name, First name, M.I.	Social Security no. required*	Sex	Age	Date of birth (MM/DD/YY)	Height	Weight	Current tobacco user	Disabled
Employee			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No

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

Section 3: Enrollment information (continued)

Employee home street address	City	State	ZIP code	County

Employee home phone	Employee work phone	Employee email address

Dependent home street address – if different from employee	City	State	ZIP code	Dependent names

Section 4: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 10, prior to answering the below questions.

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests (excluding AIDS and HIV) or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name: _____ Due date: ____/____/____ (MM/DD/YYYY)
4. In the last five years have you or any of your dependents been diagnosed or treated for any of the following? ☐ Yes ☐ No Check all that apply.

☐ Arthritis
☐ Back/neck disorder
☐ Blood/bleeding disorder
☐ Cancer/growth/tumor
☐ Congenital disease or birth defect
☐ Diabetes/thyroid/endocrine disorder
☐ Digestive/intestinal disorder
☐ Heart/circulatory disorder
  ☐ Aneurysm
  ☐ High blood pressure
  ☐ Coronary artery disease/heart attack
☐ Immune disorder (other than HIV)
  ☐ Lupus
☐ Infertility/reproductive organ disorder
☐ Kidney/bladder/urinary disorder
☐ Liver/pancreas disorder
☐ Mental/nervous disorder
  ☐ Depression
  ☐ Alcohol or substance abuse
☐ Muscular dystrophy
☐ Nervous system disorder
  ☐ Cerebral palsy
  ☐ Multiple sclerosis
  ☐ Seizures/epilepsy
  ☐ Migraines/cluster headaches
  ☐ Parkinson's
  ☐ Stroke
☐ Respiratory/lung disorder
  ☐ Asthma
  ☐ Bronchitis/COPD
  ☐ Emphysema

☐ Other condition: _____

Explain "Yes" answers to any question in section 3. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date (MM/DD/YY)	Date(s) of treatment	Hospitalized	Surgery	Recovered
					____/____/____	____/____/____	☐Y ☐N	☐Y ☐N	☐Y ☐N
					____/____/____	____/____/____	☐Y ☐N	☐Y ☐N	☐Y ☐N
					____/____/____	____/____/____	☐Y ☐N	☐Y ☐N	☐Y ☐N
					____/____/____	____/____/____	☐Y ☐N	☐Y ☐N	☐Y ☐N

Section 5: Waiver of coverage – Must be completed if employee and/or dependents waive medical coverage.

NOTE: If waiving coverage, please complete this section. Section 8 must also be signed and dated.

Medical coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s)

Reason for declining coverage – Check all that apply:

☐ Covered by spouse's group coverage ..... Carrier name: _____ ID no.: _____
☐ Enrolled in other insurance provided by my employer Carrier name: _____ ID no.: _____
☐ Enrolled in individual coverage ..... Carrier name: _____ ID no.: _____
☐ Spouse covered by employer's group medical coverage
☐ Medicare
☐ Other: _____
☐ No coverage

Section 6: Other health insurance information

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No				
Family members covered by other health coverage				
Insurance company name		Policy no.		Effective date (MM/DD/YYYY)
Insurance company street address	City	State	ZIP code	Insurance company phone no.
Policy/certificate holder's name	Social Security no.	Date of birth (MM/DD/YYYY)		Relationship to applicant
Family members covered by Medicare				Medicare ID no.
Part A effective date	Part B effective date	Medicare eligibility reason – Check all that apply ☐ Age ☐ Disability ☐ ESRD – Onset date: (MM/DD/YYYY)		
Medicare Part D carrier	Medicare Part D ID no.	Part D effective date	Part D termination date	

Section 7: Over-age Dependent Affidavit

By initialing below, I verify and attest that my dependent(s), age 26 and over, is/are unmarried and financially or otherwise dependent on me due to mental and/or physical disability; and therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year as specified by the certificate. I understand that Anthem reserves the right to request, at any time, proof of over-age dependency.

Initials: _____