

Enrollment Application

Anthem Balanced Funding



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: <u>PPO</u>				

Reason for application

☐ New enrollment	☐ Add	☐ Change	Qualifying event-- please complete date and reason. Event date: [] [] [] [] (MM/DD/YY) ☐ Marriage ☐ Divorce ☐ Birth of child ☐ Adoption ☐ Terminated employment ☐ Other: _____
☐ Open enrollment	☐ Cancel		
☐ COBRA Event: _____			
Date: [] [] [] [] (MM/DD/YY)			
☐ Waive			

Section 2: Group information

Group name <u>VANDERBURGH COUNTY</u>		Group no. <u>W12948M001</u>		Subgroup no.	
Group street address <u>1 NW M L KING JR BLVD</u>		City <u>EVANSVILLE</u>		State <u>IN</u>	
Employee status ☐ Active ☐ Disabled ☐ Retired ☐ Other: _____		Hours working per week		Income reported by ☐ 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.

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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.

- Do you or your dependents regularly take medication? ☐ Yes ☐ No
- 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
- Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
If yes, name: _____ Due date: _____ (MM/DD/YYYY)
- 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	☐ Digestive/intestinal disorder	☐ Infertility/reproductive organ disorder	☐ Muscular dystrophy
☐ Back/neck disorder	☐ Heart/circulatory disorder	☐ Kidney/bladder/urinary disorder	☐ Nervous system disorder
☐ Blood/bleeding disorder	☐ Aneurysm	☐ Liver/pancreas disorder	☐ Cerebral palsy
☐ Cancer/growth/tumor	☐ High blood pressure	☐ Mental/nervous disorder	☐ Multiple sclerosis
☐ Congenital disease or birth defect	☐ Coronary artery disease/heart attack	☐ Depression	☐ Seizures/epilepsy
☐ Diabetes/thyroid/endocrine disorder	☐ Immune disorder (other than HIV)	☐ Alcohol or substance abuse	☐ Stroke
	☐ Lupus		☐ 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: _____