Enrollment Application
Group size 51+ eligible employees

Anthem BlueCross BlueShield AnthemLife

INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

Section 1: Employer/group use — Required

Employer name		Employer address		
Vanderburgh County		**1 N.W. Martin Luther King Blvd., Evansville, IN 47708**		
Group no. **000235429**	Sub-group no./Life division no.	Requested effective date (MM/DD/YYYY)	Employee no.	Dept. name

Section 2: Reason for application — Required

☐ New enrollment ☐ New hire ☐ Add dependent (Fill in section 3)
☐ Annual open enrollment (N/A to Life) ☐ Rehire — Date: _____ (MM/DD/YYYY)
☐ COBRA — Qualifying event: _____ COBRA event date: _____ (MM/DD/YYYY)
☐ Waiver (To decline ALL coverage skip to section 11)

Section 3: Status change/event — Required, if you checked "Add dependent" option in section 2.

Event date (MM/DD/YYYY)	☐ Marriage ☐ Birth ☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation) ☐ Loss of coverage (reason): _____ ☐ Terminated employment ☐ Other: _____

Section 4: Plan/type of coverage — Required. To decline a plan type, check "No coverage".

Medical — If multiple medical plans are available, please indicate the plan type below and write plan number in the space provided.		
☐ PPO ☐	☐ HSA PPO (1) ☐	☐ No Coverage ☐
Type of medical coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage		
Vision		
Type of vision coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage		

1 Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your employer.

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

Employee name	Social Security no.[1] (required)

Section 5: Employee information — Required

Last name	First name	M.I.	Social Security no.[1] (required)

Date of birth (MM/DD/YYYY)	Age	Sex	Marital status	Height	Weight
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced		

Home phone no.	Business phone no.	Email address

Street address	City	State	ZIP code	County

Retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ No	Occupation	Hours working per week	Full-time hire date (MM/DD/YYYY)	Income reported by: ☐ W-2 ☐ 1099 ☐ Other: _____

Primary Care Physician (PCP)	PCP ID no.	Current patient
		☐ Yes ☐ No

Section 6: Family information — Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 4 of the application, under section 9, Significant Terms, Conditions and Authorizations, prior to answering the questions in section 6.

Spouse/Domestic partner last name	First name	M.I.	Social Security no.[1] (required)

Date of birth (MM/DD/YYYY)	Sex	Relationship to employee	Height	Weight
	☐ Male ☐ Female	☐ Spouse ☐ Domestic Partner		

Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

If spouse/DP address is different than employee, please provide full address

Primary Care Physician (PCP)	PCP ID no.	Current patient
		☐ Yes ☐ No

Dependent last name	First name	M.I.	Social Security no.[1] (required)

Date of birth (MM/DD/YYYY)	Sex	Relationship to employee	Full-time student?	Height	Weight
	☐ Male ☐ Female	☐ Child ☐ Other: _____	☐ Yes ☐ No		

Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

Court ordered health care coverage? ☐ Yes ☐ No (If yes, attach legal documentation)

If dependent address is different than employee, please provide full address

Primary Care Physician (PCP)	PCP ID no.	Current patient
		☐ Yes ☐ No

Dependent last name	First name	M.I.	Social Security no.[1] (required)

Date of birth (MM/DD/YYYY)	Sex	Relationship to employee	Full-time student?	Height	Weight
	☐ Male ☐ Female	☐ Child ☐ Other: _____	☐ Yes ☐ No		

Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

Court ordered health care coverage? ☐ Yes ☐ No (If yes, attach legal documentation)

If dependent address is different than employee, please provide full address

Primary Care Physician (PCP)	PCP ID no.	Current patient
		☐ Yes ☐ No

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Employee name	Social Security no.[1] (required)

Section 8: Other health coverage — Required

Do you and/or your dependents have other health coverage? __ Yes __ No If yes, complete below.

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 no.	Effective date

Policy/certificate holder name	Social Security no.[1] (required)	Date of birth (MM/DD/YYYY)	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? __ Yes __ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	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)

Have you and/or your dependents had prior health coverage? __ Yes __ No If yes, complete below.

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No	Policy/certificate no.	
Group name/ID no.	Date policy in effect	Date policy termed

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No

List prior carrier(s)	Date policy in effect	Date policy termed

Please check the type of prior coverage: ☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other ☐ Death of spouse/DP

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

Employee name	Social Security no.[1] (required)

Section 9: Significant Terms, Conditions and Authorizations (TERMS) — Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Anthem program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

6.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security Number listed on this application is correct.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature — Required, if you are applying for coverage. Please review your application for errors or omissions.

Read section 9 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MM/DD/YYYY)
X	

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