

# Enrollment Application

## Group size 51+ eligible employees



### 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 Vanderburgh County		Employer address 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

<input type="checkbox"/> New enrollment	<input type="checkbox"/> New hire	<input type="checkbox"/> Add dependent (Fill in section 3)
<input type="checkbox"/> Annual open enrollment (N/A to Life)	<input type="checkbox"/> Rehire — Date: _____ (MM/DD/YYYY)	
<input type="checkbox"/> COBRA — Qualifying event: _____		COBRA event date: _____ (MM/DD/YYYY)
<input type="checkbox"/> 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)	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption (Attach legal documentation) <input type="checkbox"/> Legal guardianship (Attach legal documentation) <input type="checkbox"/> Loss of coverage (reason): _____ <input type="checkbox"/> Terminated employment <input type="checkbox"/> Other: _____
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### Section 4: Plan/type of coverage — Required. To decline a plan type, check “No coverage”.

<b>Medical — If multiple medical plans are available, please indicate the plan type below and write plan number in the space provided.</b>		
<input type="checkbox"/> PPO	<input type="checkbox"/> HSA PPO (1)	<input type="checkbox"/> No Coverage
<b>Type of medical coverage:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse (DP) <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage		
<b>Vision</b>		
<b>Type of vision coverage:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse (DP) <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> 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
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Social Security no. <sup>1</sup> (required)
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**Section 5: Employee information — Required**

Last name		First name			M.I.	Social Security no. <sup>1</sup> (required)	
Date of birth (MM/DD/YYYY)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			Height	Weight
Home phone no.		Business phone no.		Email address			
Street address			City		State	ZIP code	County
Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation		Hours working per week	Full-time hire date (MM/DD/YYYY)		Income reported by: <input type="checkbox"/> W-2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____	
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Primary Care Physician (PCP)				PCP ID no.		Current patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

<b>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.</b>							
Spouse/Domestic partner last name		First name			M.I.	Social Security no. <sup>1</sup> (required)	
Date of birth (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			Height	Weight	
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent last name		First name			M.I.	Social Security no. <sup>1</sup> (required)	
Date of birth (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Height	Weight
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give reason: _____							
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent last name		First name			M.I.	Social Security no. <sup>1</sup> (required)	
Date of birth (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Height	Weight
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give reason: _____							
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	

<sup>1</sup> Anthem is required by the Internal Revenue Service to collect this information.

Employee name

Social Security no.<sup>1</sup> (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. <sup>1</sup> (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

Group name/ID no.	Policy/certificate no.	Date policy in effect	Date policy terminated
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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 terminated
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Please check the type of prior coverage:  Employee  Employee+Spouse/DP  Employee+Child(ren)  Employee+Spouse/DP+Child(ren)

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

<sup>1</sup> Anthem is required by the Internal Revenue Service to collect this information.

Employee name

Social Security no.<sup>1</sup> (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 X	Date (MM/DD/YYYY)
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