Employee Change Form Application

Anthem

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing Section 1, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections. Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing **www.anthem.com**. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through **www.anthem.com**.

EMPLOYER USE ONLY			
Group no.	Sub-group no.	Applicant no./dept. name	Request effective date (MM/DD/YYYY)
Employer name		Address (please include suite no., city, state, ZIP code)	
ANTHEM USE ONLY			
Plan		PCP ☐ Yes ☐ No	COB ☐ Yes ☐ No
Health effective date (MM/DD/YYYY)	Dental effective date (MM/DD/YYYY)	Vision effective date (MM/DD/YYYY)	Pre-ex date (MM/DD/YYYY)

Section 1. REASON FOR CHANGE

☐ Event date (MM/DD/YYYY)

☐ Address
☐ Cancel dependent
☐ Benefit change
☐ PCP change
☐ Name change
☐ Enrollment in Medicare
☐ Cancel/waiving coverage (see Section 8)
☐ Conversion
☐ Other _____

Section 2. TYPE OF COVERAGE/PLAN

Health coverage	Dental coverage	Vision coverage
☐ HMO*[1] (except Ohio) ☐ PPO _____ ☐ Lumenos® Health Savings Account ☐ EPO (Ohio only) ☐ POS* ☐ Lumenos® Health Reimbursement Account ☐ Blue Traditional® ☐ Lumenos® Health Incentive Account ☐ Anthem Essential℠ PPO ☐ Lumenos® Health Incentive Account Plus ☐ Anthem Essential℠ Choice PPO ☐ Anthem Essential℠ Select ☐ Blue Access℠ Hospital Surgical PPO (IN, KY, OH only) ☐ Blue Access℠ Hospital Surgical PPO (MO only) ☐ Blue Access℠ Choice Hospital Surgical PPO (MO only) ☐ Blue Preferred® Select ☐ Blue Preferred® ASO/EPO ☐ Blue Preferred® Plus Hospital Surgical POS (WI only) [1]Ohio only-a health insuring corporation product or "HIC" Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.	☐ PPO _____ ☐ Traditional (IN, OH only) ☐ Dental Blue® 100/200/300 ☐ Dental Blue® 100	☐ Vision _____
☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage	☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage	☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application, the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian*, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross and Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross and Blue Shield with information about my HSA, including account number, account balance and information, regarding account activity. I also understand that I may provide Anthem Blue Cross and Blue Shield with a written request to revoke my authorization at any time.

Policyholder name	Policyholder social security no.

Section 3. EMPLOYEE INFORMATION (*Only complete Primary Care Physician (PCP) information for HMO or POS products.)

Social security no. (required)	Last name	First name	M.I.	Date of birth (MM/DD/YYYY)

Home address (street, city, state, ZIP code)	County (KY residents include municipality)	☐ Single ☐ Divorced ☐ Married	Sex ☐ M ☐ F

Home phone	Work phone	E-mail address	Hours worked per week

Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?* ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

Section 4. FAMILY INFORMATION – Spouse and dependents to be changed/cancelled. Attach a separate sheet if necessary.

***Only complete Primary Care Physician (PCP) information for HMO or POS products.**

1 – ☐ Change ☐ Cancel | Reason for change:

Dependent name (last name, first name, M.I.)	Social security no. (required for spouse or DP)	Sex ☐ M ☐ F	Date of birth

Relationship to employee ☐ Spouse ☐ Domestic Partner (DP) ☐ Son ☐ Daughter ☐ Other _____	Is dependent's address different than applicant's address? ☐ Yes ☐ No If yes, please provide full address _____

Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?* ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

2 – ☐ Change ☐ Cancel | Reason for change:

Dependent name (last name, first name, M.I.)	Social security no.	Sex ☐ M ☐ F	Date of birth

Relationship to employee ☐ Spouse ☐ Domestic Partner (DP) ☐ Son ☐ Daughter ☐ Other _____	Is dependent's address different than applicant's address? ☐ Yes ☐ No If yes, please provide full address _____

Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?* ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

3 – ☐ Change ☐ Cancel | Reason for change:

Dependent name (last name, first name, M.I.)	Social security no.	Sex ☐ M ☐ F	Date of birth

Relationship to employee ☐ Spouse ☐ Domestic Partner (DP) ☐ Son ☐ Daughter ☐ Other _____	Is dependent's address different than applicant's address? ☐ Yes ☐ No If yes, please provide full address _____

Anthem PCP name*	Anthem PCP address*	Anthem PCP ID no.*	New patient?* ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

Section 5. OTHER HEALTH COVERAGE Please check one: ■ Yes (complete below) ■ No

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Name of person(s) covered	Relationship to employee ☐ Self ☐ Spouse ☐ Child(ren)	Name of the HMO or insurance company	Policy/certificate no.

Address of the HMO or insurance company	Phone no. of HMO or insurance co.	Effective date (MM/DD/YYYY)

Policyholder name	Policyholder social security no.	Policyholder date of birth

Policyholder name	Policyholder social security no.

Section 6. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare or Medicaid, complete the following.

1 – Last name of enrollee		First name		M.I.
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 ☐ End stage renal disease (ESRD) ☐ ESRD and disability				
2 – Last name of enrollee		First name		M.I.
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 ☐ End stage renal disease (ESRD) ☐ ESRD and disability				
3 – Last name of enrollee		First name		M.I.
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 ☐ End stage renal disease (ESRD) ☐ ESRD and disability				

Section 7. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit 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.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application 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.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself. I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment in the benefit plan. 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 benefit rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission of cancellation of my benefits.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto 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.

Applicant signature **X**	Date

Policyholder name	Policyholder social security no.

Section 8. WAIVER OF COVERAGE – For employee and/or any eligible dependent not enrolling.

Check all that apply:

Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name, ID no.)

Check all that apply:

Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name, ID no.)

Check all that apply:

Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name, ID no.)

Check all that apply:

Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name, ID no.)

Check all that apply:

Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name, ID no.)

I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits 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 benefit booklet, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his/her 19th Birthday. 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. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Applicant signature	Date
X	