Employee Enrollment Supplemental Form
EmployeeElect for 1-50 Employee Small Groups in Colorado

Anthem BlueCross BlueShield

This form is to accompany the *Colorado Uniform Employee Application for Small Group Health Benefit Plans*. Please complete in black ink/type, using all capital letters. To avoid delays, please answer all questions completely, sign and date your application, and return it to your employer.

Group no.

Social Security or member no.

SECTION 1: MEDICAL COVERAGE — Please ask your employer which medical plans are available, and check your selection

- ☐ PPO $1,250 B
- ☐ PPO $1,000 B
- ☐ PPO $1,500 G
- ☐ PPO $750 G
- ☐ PPO $2,000 X
- ☐ PPO $3,000 X
- ☐ PPO $5,000 S
- ☐ PPO $3,000 S
- ☐ PPO $2,000 S
- ☐ PPO $1,500 S
- ☐ PPO $1,000 S
- ☐ PPO $500 S
- ☐ Lumenos HSA $5,000/100% *
- ☐ Lumenos HSA $3,000/80% *
- ☐ Lumenos HSA $2,000/80% *
- ☐ Lumenos HRA $5000
- ☐ Lumenos HRA $4000
- ☐ Lumenos HRA $3000
- ☐ Blue Priority $2,000
- ☐ Blue Priority $1500
- ☐ Blue Priority $1000
- ☐ Blue Priority PPO $2000
- ☐ Blue Priority PPO $1,000
- ☐ HMOSelect $45 Copay GenRx $1,500D
- ☐ HMOSelect $40 Copay $1,000D
- ☐ Classic HMO*Select*
- ☐ PPO Basic
- ☐ PPO Standard
- ☐ HMO Basic
- ☐ HMO Standard

*Confirm with your employer which HSA custodian was selected.

Other plan

SECTION 2: DENTAL COVERAGE

- ☐ Dental PPO Option 1
- ☐ Dental PPO Option 1 with Ortho
- ☐ Dental PPO Option 2
- ☐ Dental PPO Option 3
- ☐ Dental PPO Option 3 with Ortho
- ☐ Dental PPO Option 4
- ☐ Dental PPO Plus Option 1
- ☐ Dental PPO Plus Option 1 with Ortho
- ☐ Dental PPO Plus Option 2
- ☐ Dental PPO Plus Option 3
- ☐ Dental PPO Plus Option 3 with Ortho
- ☐ Dental PPO Plus Option 4

SECTION 3: VISION COVERAGE — Please ask your employer which vision plans are available, and check your selection

☐ Blue View OR ☐ Blue View Plus

SECTION 4: LIFE AND DISABILITY COVERAGE — Please ask your employer what coverage(s) are being offered, and check your selection(s)

- ☐ Life and AD&D
- ☐ Dependent Life
- ☐ Short-Term Disability
- ☐ Long-Term Disability
- ☐ Supplemental Life; please select one:
  - ☐ $15,000
  - ☐ $25,000
  - ☐ $50,000
  - ☐ $100,000

Primary beneficiary–name	Relationship	Social Security no.	Percentage *
Primary beneficiary–name	Relationship	Social Security no.	Percentage *
Contingent beneficiary–name	Relationship	Social Security no.	Percentage **
Contingent beneficiary–name	Relationship	Social Security no.	Percentage **

*If choosing multiple primary beneficiaries total must add up to 100%
**If choosing multiple contingent beneficiaries total must add up to 100%

Please use a separate sheet, if needed, to list additional beneficiaries.

SECTION 5: EMPLOYEE INFORMATION — Must be completed by employee

Reason for completing application:

☐ New enrollment ☐ Changing coverage ☐ Changing PCP ☐ Changing beneficiary ☐ Changing personal information ☐ Terminating coverage

☐ COBRA: qualifying event _____ Effective date _____

☐ Other: qualifying event _____ Effective date _____

Last name	First name	M.I.	Social Security or member no.

Salary (required)	Email address
$_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly	

Social Security or member no.

SECTION 6: DECLINING COVERAGE — Complete this section only if you want to decline coverage(s) for yourself and/or any eligible dependent(s)

Type of Coverage:	Declined for:	Please write in "A", "B", "C", etc. per the list below to identify reason for declining (proof of other coverage may be required).
Dental plan	☐ Self ☐ Spouse ☐ Child(ren)	A. Covered by another group plan; carrier and ID are: _____
Vision plan	☐ Self ☐ Spouse ☐ Child(ren)	B. Covered by individual policy; carrier and ID are: _____
Life	☐ Self ☐ Dependents	C. Covered by military service insurance D. Have no other insurance coverage and am not interested E. I and/or my dependent(s) have coverage under a state child health insurance program or state Medicaid plan F. Other: _____
Disability	☐ Self ☐ Dependents	

I UNDERSTAND THAT:

- If I decline coverage under a PPO policy and have no other group or individual health coverage at this time, I and my dependent(s) will not be able to enroll until the next open enrollment period subject to an exclusion of coverage for pre-existing conditions for a period of up to 6 months.
- If I decline coverage under an HMO policy I and my dependent(s) will not be able to enroll until the next open enrollment period.
- If I decline coverage for myself and/or my dependent(s) (including my spouse) because of other group or individual insurance coverage except coverage under a state child health insurance program or a state Medicaid plan, I may in the future be able to enroll myself and/or my dependent(s) in this plan if I and/or my dependent(s) lose eligibility for that other coverage, provided that I request enrollment within 31 days after that other coverage ends. In addition, if I have a new 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 for adoption. You have the right to obtain a Certificate of Creditable Coverage from your prior plan. Please contact customer service at the number listed on your health benefit ID card for assistance in obtaining such certificate or if you have questions regarding pre-existing conditions.
- I may be required to submit additional information upon request.
- If I decline coverage for myself and/or my dependent(s) because of coverage under a state child health insurance program and I and/or my dependent(s) lose eligibility for that coverage, I must request enrollment for this group coverage within 90 days after the date the coverage under the state child health insurance program ends.
- If I decline coverage for myself and/or my dependent(s) because of coverage under a state Medicaid plan and I and/or my dependent(s) lose eligibility for that coverage, I must request enrollment for this group coverage within 60 days after the date the coverage under the state Medicaid plan ends.
- If I become eligible for state premium assistance for group coverage, I must request enrollment for this group coverage within 60 days after the date I become eligible for state premium assistance.
- If I decline life and/or disability coverage for any reason, my dependents and I may enroll in the future as late entrants only if we provide satisfactory proof of insurability.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application. The plan has been explained to me, and I decline to participate.

Employee signature if **declining** coverage for self/dependent(s)	Date
X	

SECTION 7: AUTHORIZATION — The following Authorization is to be signed by the employee applying for coverage

I AM APPLYING FOR LIFE AND/OR DISABILITY COVERAGE: I understand that I am submitting this application to Anthem Life Insurance Company (Anthem Life) and that if one or more of the following circumstances apply, then the health history information on my Colorado Uniform Employee Application for Small Group Health Benefits Plans will be used by Anthem Life to determine whether or not life and/or disability insurance will be offered to me. 1) the date of this application is more than 31 days after my eligibility date for coverage; 2) the amount of term life coverage I am applying for is more than the guaranteed issue limit; 3) I am applying for long term disability coverage and my employer has less than six enrolled employees. I understand that if I am not actively at work on the date my insurance would otherwise become effective, the insurance will not become effective until I return to active work.

Signature of employee (if applying for life and/or disability coverage)
X

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back pages, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado and me.

Employee signature	Date	Spouse signature (if applying for coverage)	Date
X		**X**	

Social Security or member no.

SECTION 8: EMPLOYEE AUTHORIZATION, NOTICE AND REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE

My signature on page 2 of this application acknowledges my agreement with the Authorization below.

I understand that Anthem Life may collect personal information about me from outside sources and that both personal and privileged information may be disclosed to outside parties without my authorization only if such disclosure is permitted by applicable federal and state law. I also understand that under applicable federal and state law, I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem Life.

For the purpose of evaluating my health statement for Anthem Life coverage, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc. (MIB); or other organization, institution or person that has any records or knowledge of me or my health or that of my family for whom this health statement is made or their health to give Anthem Life or its reinsurers any such information. I also authorize Anthem Life or its reinsurers to release any information regarding me or my health or that of my family for whom insurance application is made to the MIB; or other life insurance companies with which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand this information will be used by Anthem Life to determine eligibility for insurance. This information includes any record or knowledge about medical history, including information contained in such records relating to sensitive services such as mental health, psychiatric, substance abuse, reproductive health, and information about HIV virus or AIDS, sexually transmitted or other communicable diseases. This includes but is not limited to all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. This authorization, for purposes of processing this application, will be valid from the date signed for a period of 30 months, and a photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy. For the purposes of processing a claim under this coverage, this authorization is valid for the duration of the claim.

I certify that I have read, or have had read to me, the completed health statement and that I realize any false statement or misrepresentation in the health statement may result in loss of coverage under the policy.

EMPLOYEE REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE

Your signature on this application acknowledges your agreement with the following representations.

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract subject to change by my written notice to my employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages, if necessary, for the required premium for the coverage for which I have applied.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I am applying for the coverage selected on this application. If I select a coverage, or a 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.
5. I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provision as a condition of coverage. 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 the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). A photocopy is as valid as the original.

I give this representation for and on behalf of myself and my eligible dependents, including my children and my spouse if covered by the plan. I am acting as their agent and representative.

The employee and any person authorized to act on behalf of the employee, is entitled to receive a copy of this representation and will be provided a copy of this application upon their request.

IMPORTANT NOTICE

Information regarding your insurability will be treated as confidential. Anthem Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal *Fair Credit Reporting Act*. The address of MIB's information office is PO Box 105, Essex Station, Boston, MA 02112.

Anthem Life or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. You may want to keep a copy of this statement for your records.