Employee Change Form

Anthem BlueCross BlueShield

Anthem Life

INSTRUCTIONS:

Please complete this form ONLY if you are 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.

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in blue or black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing **www.anthem.com**.

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name		Employer address		
Group no.	Sub-group no./ Life division no.	Requested effective date	Life classification	Employee no./Dept. name

SECTION 2: REASON FOR CHANGE - Required. Please be sure to provide date of event.

Event date

- ☐ Address
- ☐ Name change
- ☐ Benefit change
- ☐ Add dependent
- ☐ Cancel dependent
- ☐ Conversion
- ☐ Change Life beneficiary
- ☐ Change Life classification
- ☐ Other_____
- ☐ Enrollment in Medicare (Fill in Section 7)
- ☐ Waiving coverage (Fill in Section 10)

SECTION 3: PLAN/TYPE OF COVERAGE

Medical
If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.

Type of coverage

- ☐ HMO
- ☐ POS
- ☐ PPO
- ☐ Anthem Essential℠ PPO
- ☐ Lumenos® HSA PPO*
- ☐ Lumenos® HRA PPO
- ☐ Lumenos® HIA PPO
- ☐ Lumenos® Health Incentive Account Plus PPO
- ☐ Lumenos® Deductible First HRA PPO

If multiple Medical Plans are available, write plan number:

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

- ☐ Employee only
- ☐ Employee+spouse (DP)
- ☐ Employee+child(ren)
- ☐ Family coverage
- ☐ No coverage

Dental
To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.

- ☐ PPO_____
- ☐ Traditional
- ☐ Dental Blue®100/200/300
- ☐ Dental Blue® 100

Type of coverage

- ☐ Employee only
- ☐ Employee+spouse
- ☐ Employee+child(ren)
- ☐ Family coverage
- ☐ No coverage

Vision

Type of coverage

- ☐ Employee only
- ☐ Employee+spouse (DP)
- ☐ Employee+child(ren)
- ☐ Family coverage
- ☐ No coverage

Life

- ☐ Life (Fill in Section 6)

SECTION 4: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)

Sex ☐ M ☐ F	☐ Single ☐ Married ☐ Divorced	Height	Weight	Home phone	Email address	Hours worked per week

Address	City	State	ZIP code	County

SECTION 5: FAMILY INFORMATION – Spouse and dependents to be changed/cancelled, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information in Section 8, Significant Terms, prior to answering the questions in Section 5.

Spouse/Domestic Partner

☐ Add ☐ Change ☐ Cancel	Reason for change		
Last name	First name	M.I.	Social security no. (required)

Date of birth	Sex ☐ M ☐ F	Relationship to employee ☐ Spouse ☐ Domestic Partner	If spouse/DP address is different than employee, provide full address

Employee name _____ Social security no._____

SECTION 5: FAMILY INFORMATION – CONTINUED. Spouse and dependents to be changed/cancelled, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information in Section 8, Significant Terms, prior to answering the questions in Section 5.

Dependent

☐ Add ☐ Change ☐ Cancel	Reason for change		
Last name	First name	M.I.	Social security no.
Date of birth	Sex ☐ M ☐ F	Relationship to employee ☐ Child ☐ Other_____	If dependent address is different than employee, provide full address

Dependent

☐ Add ☐ Change ☐ Cancel	Reason for change		
Last name	First name	M.I.	Social security no.
Date of birth	Sex ☐ M ☐ F	Relationship to employee ☐ Child ☐ Other_____	If dependent address is different than employee, provide full address

SECTION 6: LIFE AND DISABILITY INSURANCE

Current income $_____ ☐ Hour ☐ Week ☐ Month ☐ Year

Currently actively at work ☐ Yes ☐ No If no, reason

☐ Basic Life
☐ Dependent Life
☐ Supplemental Life _____ x annual earnings OR $_____
☐ Basic AD&D
☐ Optional AD&D
☐ Short-Term Disability_____
☐ Long-Term Disability _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

☐ Short-Term Disability_____% ☐ Long-Term Disability_____% ☐ Basic Life

Primary beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

Contingent beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

SECTION 7: OTHER HEALTH COVERAGE

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.	Date of birth	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)

SECTION 8: 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 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 Blue Cross and Blue Shield at any time.

Employee name _____ Social security no._____

SECTION 8: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
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 understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. 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.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

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.

SECTION 9: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 8 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

SECTION 10: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ Medical	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Dental	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Vision	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Life	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ All	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.

Check all that apply:

☐ I have been given a chance to apply for Anthem Blue Cross and Blue Shield coverage, and after careful thought, I have decided not to take this offer. If I want to apply for coverage at a later date, I can, based on established methods. If I have decided not to take this offer of coverage for myself or my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents later, as long as I ask to sign up within 31 days after other coverage ends. If my dependent or I are late enrollees, we may be subject to pre-existing conditions restrictions or waiting periods set out in the group certificate. The pre-existing exclusion may not apply to dependents enrolled in the plan before their 19th birthday. Also, 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 if I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may sign up under two more circumstances:

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

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

☐ I have been given a chance to apply for the group life benefits offered by my employer/group. The benefits have been explained to me. I and/or my dependent(s) have decided not to join. My dependent(s) or I were not pressured by my employer/group, agent or life carrier, to say no to this coverage, but instead we chose to say no of our own accord. I agree that if I want to ask for coverage in the future, I may be asked to give proof of insurability at my own cost.

☐ Other:_____

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature X	Date