Employee Change Form Application

Anthem Anthem Life

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 2, 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.**

1. Employer/Group Use: Employer Name and Address:					
Group #	Sub-group #/Life Division #	Request Effective Date	Life Classification	Applicant #/Dept. name	
Anthem use: Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP ☐ Yes ☐ No / COB ☐ Yes ☐ No / Pre-ex (date)
	/ /	/ /	/ /	/ /	/ /

2. Reason for Change

Event date ___/___/___

- ☐ Address
- ☐ Change Life Beneficiary
- ☐ Change Life Classification
- ☐ Enrollment in Medicare (see section 7)
- ☐ Cancel/Waiving Coverage (Refer to section 9)
- ☐ Conversion
- ☐ Benefit change
- ☐ Cancel dependent
- ☐ PCP change
- ☐ Name change
- ☐ Other _____

3. Type of Coverage/Plan

Health Coverage

- ☐ HMO* ☐ POS* ☐ PPO ____
- ☐ Anthem Essential℠ PPO
- ☐ Anthem Essential℠ POS
- ☐ Blue Preferred® Plus Hospital Surgical POS
- ☐ Lumenos® HSA ____ PPO ____ POS
- ☐ Lumenos® HRA ____ PPO ____ POS
- ☐ Lumenos® HIA ____ PPO ____ POS
- ☐ Lumenos® Health Incentive Account Plus ___ PPO ___ POS
- ☐ Employee only
- ☐ Employee + spouse ☐ Family coverage
- ☐ Employee + child(ren) ☐ No coverage

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

Dental Coverage

- ☐ PPO _____
- ☐ DentaCare (HMO)
- ☐ Dental Blue® 100/200/300
- ☐ Dental Blue® 100
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☐ No coverage

Vision Coverage

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + child(ren)
- ☐ Family Coverage
- ☐ No coverage

Life Coverage

- ☐ Life (see section 6)

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.

4. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth / /	Sex ☐ M ☐ F	Social Security # (required) - -	☐ Single ☐ Divorced ☐ Married	Height	Weight

Home address	City	State	Zip code	County

Hours worked per week	Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

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

5. Family Information Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. (SS # required for spouse/domestic partner)

1 ☐ Change ☐ Cancel	Last name	First name, M.I.

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to insured ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

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

2 ☐ Change ☐ Cancel	Last name	First name, M.I.

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to insured ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

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

NAME _____ SSN _____

3 ☐ Change ☐ Cancel		Last name		First name, M.I.
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to insured ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?
		☐ Yes ☐ No

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

6. Life and Disability Insurance

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability_____% ☐ Anthem By Design Short Term Disability-BUY UP

☐ Dependent Life ☐ Supplemental AD&D ☐ Long Term Disability_____% ☐ Anthem By Design Long Term Disability-BUY UP

☐ Supplemental Life: _____ x annual earnings OR $_____ ☐ Anthem By Design Basic Life-BUY UP

☐ Current Income: $_____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year* (Complete separate election form)

Are you currently actively at work? ☐ Yes ☐ No _____ If no, reason:

	Last name	First name, M.I.	Social Security # - -	Relationship to applicant	Age
Primary Beneficiary					
Contingent Beneficiary					

7. 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.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number	Effective date / /
Policy/certificate holder's name	Social security number _ _	Date of birth / /	Relationship to applicant

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

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /

Medicare Part D ID#	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)

8. 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 program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage 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 Anthem Life Insurance Company may accept only certain persons or conditions for coverage) 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 coverage.
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 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 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 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).

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	Date / /

NAME ____________________ SSN ____________________

9. 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 #)	☐ Other carrier (give name, ID #)

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 #)	☐ Other carrier (give name, ID #)

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 #)	☐ Other carrier (give name, ID #)

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 #)	☐ Other carrier (give name, ID #)

Check all that apply

☐ I represent that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage 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 certificate, 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.

☐ I represent that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.
Please check if any of the following apply: (WI only)

☐ I am covered or will be covered under another plan that is **not** sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).

☐ My dependents are covered or will be covered under another plan that is **not** sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).

☐ Other:

Applicant signature	Date / /