Employee Enrollment Supplemental Application
For 2-50 Employee Small Groups
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

- ☐ Core DirectAccess gmua
- ☐ Core DirectAccess Plus ghhb
- ☐ Core DirectAccess Plus gpdb
- ☐ Core DirectAccess Plus grdf
- ☐ Core DirectAccess Plus gtpa
- ☐ Core Guided Access Plus gjqa
- ☐ Core Guided Access Plus w/ Dental gjqa
- ☐ Essential DirectAccess gdsa
- ☐ Essential DirectAccess ggja
- ☐ Essential DirectAccess gpsa
- ☐ Essential DirectAccess gyia
- ☐ Essential DirectAccess gzia
- ☐ Essential DirectAccess Plus gcqa
- ☐ Essential DirectAccess Plus ggqa
- ☐ Essential DirectAccess Plus w/ Dental ggqa
- ☐ Essential DirectAccess Plus ghpa
- ☐ Essential DirectAccess Plus gjpa
- ☐ Essential DirectAccess Plus gnea
- ☐ Essential DirectAccess Plus gzca
- ☐ Essential Guided Access gcda
- ☐ Essential Guided Access gpja
- ☐ Preferred DirectAccess gfga
- ☐ Preferred DirectAccess gfha
- ☐ Preferred DirectAccess ghla
- ☐ Preferred DirectAccess gjha
- ☐ Preferred DirectAccess gpka
- ☐ Preferred DirectAccess Plus gfda
- ☐ Preferred DirectAccess Plus ginb
- ☐ Preferred DirectAccess Plus gmpa
- ☐ Preferred DirectAccess Plus gzpa
- ☐ Preferred DirectAccess Plus w/ Dental gzpa
- ☐ Preferred Guided Access Plus gmca
- ☐ Premier DirectAccess Plus ginb

SECTION 2: DENTAL COVERAGE – Please ask your employer which dental plans are available, and check your selection.

- ☐ Anthem Dental Adult
- ☐ Anthem Dental Adult Enhanced
- ☐ Anthem Dental Family
- ☐ Anthem Dental Family Enhanced
- ☐ Anthem Dental Pediatric
- ☐ Anthem Dental Pediatric Enhanced
- ☐ None
- ☐ 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

Full Service

- ☐ Anthem Blue View Vision A1
- ☐ Anthem Blue View Vision A2
- ☐ Anthem Blue View Vision A3
- ☐ Anthem Blue View Vision A4
- ☐ Anthem Blue View Vision A5
- ☐ Anthem Blue View Vision B1
- ☐ Anthem Blue View Vision B2
- ☐ Anthem Blue View Vision B3
- ☐ Anthem Blue View Vision B4
- ☐ Anthem Blue View Vision C1
- ☐ Anthem Blue View Vision C2
- ☐ Anthem Blue View Vision C3
- ☐ Anthem Blue View Vision C4

Materials Only Plans

- ☐ Anthem Blue View Vision MO1
- ☐ Anthem Blue View Vision MO2
- ☐ None

☐ Blue View OR ☐ Blue View Plus

SECTION 4: LIFE AND DISABILITY COVERAGE – Check all that you are applying for. Coverage is limited to what is offered by employer.

- ☐ Basic Life (complete beneficiary designation below)
- ☐ Basic AD&D (complete beneficiary designation below)
- ☐ Basic Dependent Life
- ☐ Optional Life (only available with Basic Life)
  _____ x annual earnings OR $ _____
  If plan allows, check to add one or both:
  - ☐ Optional Employee AD&D (equal to Optional Life amount)
  - ☐ Optional Dependent Life: Spouse $ _____ Child $ _____
- ☐ Short Term Disability (STD). If plan allows, include Buy-up STD? ☐ Yes ☐ No
- ☐ Long Term Disability (LTD). If plan allows, include Buy-up STD? ☐ Yes ☐ No
- ☐ Voluntary Short Term Disability (VSTD)
- ☐ Voluntary Long Term Disability (VLTD)
- ☐ Voluntary Life (complete beneficiary designation below)
  _____ x annual earnings OR $ _____
  If plan allows, check to add one or both:
  - ☐ Voluntary Employee AD&D (equal to Voluntary Life amount)
  - ☐ Voluntary Dependent Life: Spouse $ _____ Child $ _____
- ☐ Voluntary Employee AD&D
- ☐ Voluntary Dependent Life
- ☐ Voluntary AD&D

- ☐ Life and AD&D
- ☐ Dependent Life
- ☐ Short-Term Disability
- ☐ Long-Term Disability
- ☐ Supplemental Optional 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.

Social Security or member no.

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 no.

Email address

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

Are you actively at work? ☐ Yes ☐ No
If yes, state reason: _____

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	**If Waiving Coverage, Information Will Appear on the Following Page(s)**		**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**
Vision plan			
Life			
Disability			

If declining for specific child, please include child's name: Dental _____ Vision _____

I UNDERSTAND THAT:

- If I previously declined coverage for myself and/or my dependents, I and/or my dependents (an individual) may enroll during a Special Enrollment period, as defined by law, if any of the following qualifying events has occurred:
  - An individual loses coverage under a health benefit plan due to the death of a covered employee; the termination or reduction in number of hours of the covered employee's employment; or the covered employee becoming eligible for benefits under Title XVIII of the Federal "Social Security Act," as amended;
  - An individual loses coverage under a health benefit plan due to the divorce or legal separation of the covered employee from the covered employee's spouse or partner in a civil union;
  - An individual becomes a dependent or a covered person through marriage, civil union, birth, adoption, or placement for adoption, by entering into a designated beneficiary agreement pursuant to Article 22 of Title 15, C.R.S., or pursuant to a court or administrative order mandating that the individual be covered;
  - An individual loses other creditable coverage due to the termination of his or her employment or eligibility for the coverage; reduction in number of hours or employment; involuntary termination of coverage; or reduction or elimination of his or her employer's contributions toward the coverage;
  - An individual loses eligibility under the "Colorado Medical Assistance Act,' Articles 4 to 6 of Title 25.5, C.R.S., or the Children's Basic Health Plan, Article 8 of Title 25.5, C.R.S.; or
  - Any other event or circumstance occurs as set form in rules of the Commissioner defining qualifying events.
- I may be required to submit additional information upon request:
- 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 apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, 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.

Employee signature	Date
X	

Social Security or member no.

SECTION 7: COMMON-LAW AFFIDAVIT — Signatures required

We the undersigned, being of lawful age, attest to the following facts:

- We have lived together continuously, in Colorado, as husband and wife from _____ to the present.
- We are free to contract a valid ceremonial marriage, i.e., are not already married to someone else.
- We hold ourselves as husband and wife, consent to the marriage, cohabit and have the reputation in the community as being husband and wife.
- We understand that a common-law marriage, in the state of Colorado, is valid for all purposes, the same as a ceremonial marriage, and can only be terminated by death or divorce.

Employee signature	Spouse signature	Date
X	**X**	

SECTION 8: DOMESTIC PARTNER AFFIDAVIT — Signatures required

We depose and attest to the following:

1. We are both at least 18 years of age, and we are mentally competent to contract;
2. Neither of us is legally married to another person, nor is either of us a member of another domestic partnership;
3. We are sole Domestic Partners and have been sole Domestic Partners for at least 12 months preceding the date of this Affidavit. We have been sole Domestic Partners living together continuously since _____(month/day/year), and we intend to remain sole Domestic Partners indefinitely;
4. Neither related by blood closer than permitted by state law or marriage;
5. We are jointly responsible for each other's common welfare as evidenced through, for example, a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, designation of Domestic Partner as beneficiary for a life insurance or retirement contract, designation of Domestic Partner as primary beneficiary in the Employee's will, and/or powers of attorney authorizing each of us to act on behalf of the other; and
6. We understand that a Domestic Partner enrolled as a dependent ceases to be an eligible member on the first day of the month following the termination of such domestic partnership and that the Employee is required to submit an Enrollment Application/Change Form within 31 days of the termination of the domestic partnership or within the time specified in the Employee's certificate.

Employee signature	Spouse signature	Date
X	**X**	

Social Security or member no.

SECTION 9: MEDICAL AND ACTIVITIES INFORMATION — For Life and/or Disability coverage

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person who is authorized to provide advice under an alcohol or substance abuse, or weight loss program.

1. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, who? _____
   Expected due date _____
2. Have you or any of your dependents smoked or used tobacco in the past 5 years? ☐ Yes ☐ No
   If yes, who? _____
   Type _____
   Quit date _____(MM/DD/YYYY)
2. In the past 10 years, have you or any of your dependents ever:
   a. Had high blood pressure or high cholesterol? ☐ Yes ☐ No
      If yes, please indicate person and last three readings in details below:
      _____
   b. Had heart disease, cancer, diabetes, arthritis, or asthma? ☐ Yes ☐ No
   c. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition? ☐ Yes ☐ No
   d. Been treated for substance abuse or alcohol or chemical dependency, or been convicted for driving while intoxicated? ☐ Yes ☐ No
4. Have you or any of your dependents ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or tested positive for antibodies to the Human Immune Deficiency virus? ☐ Yes ☐ No
5. In the past three years have you or any of your dependents been prescribed medication? ☐ Yes ☐ No
6. In the past 10 years have you or any of your dependents had an inpatient admission and/or outpatient surgery? ☐ Yes ☐ No
7. During the past three years, have you or any of your dependents sought medical treatment, or been advised by a medical or social practitioner to seek treatment for any condition not indicated by your answers to the preceding six questions? ☐ Yes ☐ No
8. Have you or any of your dependents ever been rated or declined for, or been refused reinstatement or renewal of, life or health insurance? ☐ Yes ☐ No
9. In the past three years, have you or any of your dependents been engaged in or contemplate during the next 12 months being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? ☐ Yes ☐ No
   If yes, please list:
   _____

IMPORTANT NOTICE: No person, including an employee or agent of Anthem Life has the authority to change or omit any of these medical questions.

Explain any "Yes" in the space below. If additional space is necessary, attach a separate page including your signature and date.

Question No.	Name of individual	Name of illness or injury	Date of treatment	Remaining effects	Medication and dosage	Name and address of Physician/hospital

If Medical Information Has Been Entered it Will Appear on the Following Page(s)

SECTION 10: NOTICE OF EXCHANGE OF INFORMATION — For Life and/or Disability coverage

To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, 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. If you question the accuracy of this 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: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

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	Date
X		X	

Social Security or member no.

SECTION 11: EMPLOYEE AUTHORIZATION, NOTICE AND REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE — Read carefully before signing.

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.