Enrollment Application

Group size 2-50 eligible employees

Anthem
Anthem Health Plans of Kentucky, Inc.

Anthem Life
Anthem Life Insurance Co.

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. *All information given should apply to this employer.*

1. TYPE OF COVERAGE REQUESTED: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ Life Only ☐ No coverage

2. ENROLLMENT INFORMATION ☐ **Single** ☐ **Divorced** ☐ **Married**

Relationship	Last Name, First Name, M.I.	Social Security No. Required	Sex	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No

Employee Home Address: Street, City, State, ZIP Code	County

Employee Home Phone	Employee Work Phone	Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee)	Dependent Name(s)

3. MEDICAL INFORMATION ***(If yes, circle condition)***

*** Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.**

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name _____ due date _____
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition, cancer/tumor, disorder of the blood or immune system, stroke, aneurysm, diabetes **(list age of onset below)**, mental/nervous disorder, depression, alcohol or drug abuse/dependency, kidney, liver or pancreas disorder, ulcerative colitis, Crohn's disease, lupus, lung disorder, COPD, emphysema, arthritis, back/disk disorder, multiple sclerosis, muscular dystrophy or any other condition? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
	If Medical Information Has Been Entered It Will Appear on the Following Page(s)								
					/ /	/ /			

4. LIFE AND DISABILITY INSURANCE

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability
☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability
☐ Optional Life: _____ x annual earnings OR $_____
☐ Current Income: $ _____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

☐ Anthem By Design® Short Term Disability BUY-UP
☐ Anthem By Design® Long Term Disability BUY-UP
☐ Anthem By Design® Basic Life BUY-UP
(Complete separate election form.)

Life Class

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

5. PLEASE READ THE TERMS IN SECTION 11 CAREFULLY BEFORE SIGNING, AND REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant signature	Please Print Name	Date

Employee Name: ____ SSN: __________________________

Relationship	Name	Social Security No. Required	Sex	Age	Date of Birth	Height/Weight	Current tobacco user?	Disabled?
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other			☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No

Enrollment Application

Group size 2-50 eligible employees Name: _____ SS#: _____ _____ _____

6. PLEASE COMPLETE ALL INFORMATION

Reason for application:
- ☐ New enrollment
- ☐ Open enrollment (N/A for Life coverage)
- ☐ Qualifying event (please complete date and reason)
  Event Date ____/ ____/ ____
  - ☐ Marriage ☐ Divorce
  - ☐ Birth of Child ☐ Adoption
  - ☐ Termed Employment ☐ Other
- ☐ COBRA
  Event _____ Date ____/ ____/ ____
- ☐ State Continuation ☐ Waiver

Group Name | Group number | Sub Group Number

Group Address | Employee Hire/Rehire Date (Full time)

Employee status
- ☐ Active
- ☐ Disabled
- ☐ Retired
- ☐ Other (please explain) _____

Hours working per Week _____
If not actively working, reason _____
Projected Return Date ____/ ____/ ____

Occupation _____
Annual Salary _____

Income reported by:
- ☐ W2
- ☐ 1099
- ☐ Other (please explain) _____

7. COVERAGE SELECTION *(Availability dependent upon your employer's offering)*

Medical Coverage
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Check the medical plan you are applying for:
- ☐ PPO
- ☐ Anthem Essential℠ PPO
- ☐ HMO
- ☐ Traditional
- ☐ Blue Access® Hospital Surgical PPO
- ☐ HDHP
- ☐ HDHP/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ PPO/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ Lumenos® Health Savings Account
- ☐ Lumenos® Health Reimbursement Account
- ☐ Lumenos® Health Incentive Account
- ☐ Lumenos® Health Incentive Account Plus

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

Dental Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Vision Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

1. If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.
2. A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.

8. WAIVER OF COVERAGE SECTION: *(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)*

NOTE: If waiving coverage, please complete this section. Section 5 must also be signed and dated.

Medical Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Dental Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Vision Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Life coverage declined for: ☐ Myself

If Waiving Coverage, Information Has Been Entered It Will Appear on the Following Page(s)

Reason for Declining Coverage (check all that apply):
- ☐ Covered by spouse's group coverage - Carrier name and ID Number _____
- ☐ Enrolled in other Insurance provided by my employer - Carrier name and ID Number _____
- ☐ Enrolled in Individual coverage - Carrier name and ID Number _____
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare
- ☐ Other (Please explain) _____
- ☐ No coverage

9. PRIOR HEALTH INSURANCE INFORMATION *Prior Health Care Coverage During the past 2 years (including Anthem):*

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
If Prior Medical Has Been Entered It Will Appear on the Following Page(s)	☐ Employee Only ☐ Employee + child(ren) ☐ Employee + spouse ☐ Family		/ /	/ /

10. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No

Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date
			/ /

Policy/Certificate Holder's Name	Social Security Number	Date of birth	Relationship to applicant	Family members covered by

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Medicare ID #	Part A effective date	Part B effective date	*Medicare eligibility reason (check all that apply)*
			☐ Age ☐ Disability ☐ ESRD: Onset Date _____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date
		/ /	/ /

ANTHEM USE ONLY Coordination of Benefits? ☐ Yes ☐ No | Pre-ex (date)

Enrollment Application

Group size 2-50 eligible employees Name: _____ SS#: _____ _____ _____

11. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 5.***

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 Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross 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 Blue Shield with a written request to revoke my authorization at any time.

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.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless required by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions.
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to enrollment. This exclusion may last up to 12 months from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a dependent that is enrolled in the plan prior to his/her 19th birthday.
   I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of creditable coverage from the prior Health Insurance Carrier.
   To obtain a certificate of creditable coverage: 1. Contact the Human Resources area of your prior employer and request a certificate of creditable coverage or other evidence of prior coverage, 2. Contact your prior insurance carrier and request a certificate of creditable coverage or, if necessary, requests the steps to obtain a certificate of creditable coverage, or 3. Contact Anthem at the number on your new identification card for assistance in obtaining a certificate of creditable coverage from your prior insurance carrier. Make sure you provide your current mailing address.
   Upon receipt of your certificate of creditable coverage, forward a copy to the address on the back of your new identification card.
4. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage).
   However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). 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 dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for 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 acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 4 on page 1 and in Sections 6 through 10 on page 2 are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

By signing Section 5, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. ***Thank you for choosing Anthem Blue Cross and Blue Shield.***

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223
Anthem Life Insurance Company: P.O. Box 105448, Atlanta, GA 30348-5448