EMPLOYEE HEALTH ENROLLMENT APPLICATION

(Group Size 15+)

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. The Primary Care Physician (PCP) listings of Anthem and its affiliated HMO companies can be obtained through www.anthem.com.

APP

EMPLOYER/GROUP USE ONLY

Group Name	Group Number	Effective Date M D Y

Date of hire	Full time hire date	# Hours working per week	Date of eligibility for coverage

1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

❑ **Anthem Blue Cross and Blue Shield** _____

❑ **HealthKeepers, Inc.** _____ **(HMO)** ❑ **Priority Health Care, Inc.** _____ **(HMO)**

❑ **Peninsula Health Care, Inc.** _____ **(HMO)**

Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

2. REASON FOR APPLICATION (Check as many as apply)

❑ Initial enrollment

❑ Annual open enrollment

❑ Add dependent

❑ New hire

❑ Rehire – Date of rehire:

❑ COBRA – Qualifying Event: _____

Event Date:

❑ Birth of child

❑ Adoption or placement for adoption (attach legal documentation)

Date of adoption/ date of placement for adoption:

❑ Marriage

Date of marriage:

❑ Loss of other coverage

Date previous coverage ended:

❑ Medical child support order (attach legal documentation)

Date of order:

❑ Appointment of Legal Guardian

Effective date of appointment:

❑ Other (please specify): _____

3. TYPE OF COVERAGE/PLAN

Health Coverage

❑ Employee Only

❑ Employee and Spouse

❑ Employee and One Child

❑ Employee and Children

❑ Employee and Family

Vision Coverage

❑ Voluntary Vision

(type of coverage must match health coverage)

4. EMPLOYEE INFORMATION* (Please refer to Definitions of Eligibility, Section 9)

**If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name and PCP number.*

Social security #	Date of birth (MM/DD/YYYY)	Sex: ❑ M ❑ F

Last name	First name	M.I.

Street address	Apt. #

City	State	Zip

Daytime phone (with area code)	Evening phone (with area code)
( ) –	( ) –

Anthem PCP name* (please provide first and last name)

Anthem PCP ID number*	Current patient? ❑ Yes ❑ No

IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3

5. FAMILY INFORMATION* (If electing Employee Only coverage, skip to Section 6)

**If applying for HMO or POS coverage , list the PCP name and PCP number. Each family member may select a different PCP.*

List all family members applying for coverage. List additional dependents on a separate sheet and attach it to the application. Please indicate the relationship between you and each dependent and provide the social security number and date of birth for each covered dependent. In the event of adding a newborn for which their social security number is not available, please complete this application at this time and forward to Anthem their social security number when obtained.

Relationship to applicant ❑Spouse ❑Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❑M ❑F

Last name | First name | M.I.

Check all that apply:
a. Child to be covered by non-custodial parent due to medical child support order? ❑Yes ❑No (if yes, attach documentation)
b. Full-time student? ❑Yes ❑No
c. Disabled/ handicapped before age 23? ❑Yes ❑No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❑Yes ❑ No

Relationship to applicant ❑Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❑M ❑F

Last name | First name | M.I.

Check all that apply:
a. Child to be covered by non-custodial parent due to medical child support order? ❑Yes ❑No (if yes, attach documentation)
b. Full-time student? ❑Yes ❑No
c. Disabled/ handicapped before age 23? ❑Yes ❑No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❑Yes ❑ No

Relationship to applicant ❑Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❑M ❑F

Last name | First name | M.I.

Check all that apply:
a. Child to be covered by non-custodial parent due to medical child support order? ❑Yes ❑No (if yes, attach documentation)
b. Full-time student? ❑Yes ❑No
c. Disabled/ handicapped before age 23? ❑Yes ❑No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❑Yes ❑ No

Relationship to applicant ❑Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❑M ❑F

Last name | First name | M.I.

Check all that apply:
a. Child to be covered by non-custodial parent due to medical child support order? ❑Yes ❑No (if yes, attach documentation)
b. Full-time student? ❑Yes ❑No
c. Disabled/ handicapped before age 23? ❑Yes ❑No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❑Yes ❑ No

6. TELL US ABOUT YOUR OTHER INSURANCE

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name	Policy/ID number

Effective date (MM/DD/YY)	Please indicate whom this coverage applies to (check all that apply):
	❑Self ❑Spouse ❑All Children ❑Child: _____ (Last Name / First Name)

Do you intend to continue this coverage? ❑Yes ❑No

If no, please provide cancellation date of coverage: _____

If yes, please provide the following information:

Address of other coverage		
City	State	Zip

Phone number of other carrier/plan	Policyholder name (Last, First, M.I.)
( ) —	

Policyholder's date of birth	Type of coverage:	
	❑Health ❑Dental	

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A, B & D complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person	First name	M.I.

HIC #	Medicare Part A Effective date	Medicare Part B Effective date	Medicare Part D Effective date	65 or over: ❑Working ❑Retired

Reason for Medicare Entitlement:

❑Age ❑Disability ❑End Stage Renal Disease (ESRD) ❑ESRD & Disability

8. EMPLOYEE CERTIFICATION (Please date and sign this certification.)

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

- If the Company checked on page 1 of this application is Anthem Blue Cross and Blue Shield (Anthem), I understand that if false or misleading information is discovered within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.

- If the Company checked on page one of this application is HealthKeepers, Inc., Peninsula Health Care, Inc., or Priority Health Care, Inc., I understand that the health maintenance organization (HMO) may cancel my coverage without advance notice if it finds, within two years of the effective date of my coverage, that I misrepresented information on this application.

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

Employee Signature _____ Date _____