Employee Enrollment Application
For 51+ employee groups
Ohio

Anthem Underwritten by Community Insurance Company or Anthem Insurance Companies, Inc. AnthemLife

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MMDDYYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MMDDYYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

- ☐ New enrollment
- ☐ Annual open enrollment (not applicable to life and disability)
- ☐ New hire
- ☐ Rehire – Rehire date: _____ (MMDDYYYY)
- ☐ Marriage – Date of marriage: _____ (MMDDYYYY)
- ☐ Birth of child
- ☐ Add dependent (Fill in section 4)
- ☐ Loss of eligibility for other coverage – Date previous coverage ended: _____ (MMDDYYYY) (not applicable to life and disability)
- ☐ COBRA – Select qualifying event (not applicable to life and disability)
  - ☐ Left employment ☐ Reduction in hours ☐ Death ☐ Medicare
  - ☐ Loss of dependent child status ☐ Divorce or legal separation ☐ Covered employee's Medicare entitlement
  - Qualifying event date: _____ (MMDDYYYY)
- ☐ Waiver (To decline ALL coverage skip to section 8.)

Additional qualifying events for Life and Disability

- ☐ Marriage/Domestic Partnership/Civil Union ☐ Divorce/terminate Domestic Partnership/Civil Union
- ☐ Birth, adoption of child, legal guardianship of child ☐ Death of spouse ☐ Death of child
- ☐ Spouse left employment and lost group life insurance – applicable only for Life
- ☐ Change in class from full-time to part-time/part-time to full-time

Qualifying event date: _____ (MMDDYYYY)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Section 4: Coverage information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MMDDYYYY)	Email address (if applicable)
☐ Male ☐ Female	☐ Yes ☐ No		

Relationship to applicant: ☐ Spouse ☐ Domestic Partner

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MMDDYYYY)	Email address (if applicable)
☐ Male ☐ Female	☐ Yes ☐ No		

Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship?

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MMDDYYYY)	Email address (if applicable)
☐ Male ☐ Female	☐ Yes ☐ No		

Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship?

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MMDDYYYY)	Email address (if applicable)
☐ Male ☐ Female	☐ Yes ☐ No		

Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship?

Social Security no.* (required)

Section 6: 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 (Anthem) 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 at any time.

1. I understand that I may not assign any payment under my Community Insurance Company (Anthem) 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 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.
5. If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
7. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 CFR. Parts 160 & 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

Life and/or Disability Authorization Section — Read carefully before signing.

1. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner/Civil Union Partner. I am acting as their agent and representative.

I certify each Social Security number listed on this application is correct.

I have read and accept the 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 representation 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.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either. I understand if I change my mind after 30 months, I will need to let Anthem know. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 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	Date (MMDDYYYY)
X	