Employee Enrollment Application
For 51+ employee groups
Indiana

Anthem® 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
	W 1 0 8 9 1	

Section 1: Employee information

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

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

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

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

		☐ ☐

Section 2: Reason for application – Select one

☐ New enrollment
☐ Annual open enrollment (not applicable to life and disability)
☐ New hire
☐ Rehire – Rehire date: ____ (MM/DD/YYYY)
☐ Marriage – Date of marriage: ____ (MM/DD/YYYY)
☐ Birth of child
☐ Add dependent (Fill in section 4)
☐ Loss of eligibility for other coverage – Date previous coverage ended: ____ (MM/DD/YYYY)
☐ COBRA – Select qualifying event
- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Medicare
- ☐ Loss of dependent child status
- ☐ Divorce or legal separation
- ☐ Covered employee's Medicare entitlement

Qualifying event date: ____ (MM/DD/YYYY)

☐ Waiver (To decline ALL coverage skip to section 8.)

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

Reset Form Save and Print

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Large Group 100+ options

☐ Blue Access (PPO)

Member medical coverage – select one:

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

Dental coverage

☐ Complete Essential Choice

Member dental coverage – select one:

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

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Social Security no.* (required)

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Social Security no.* (required)

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 your children, or your spouse's children (to the end of the calendar year in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 7, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 4.

Spouse last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse ☐ Other If other, what is relationship? ______

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ______

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse ☐ Other If other, what is relationship? ______

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ______

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse ☐ Other If other, what is relationship? ______

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ______

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Social Security no.* (required)

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: ______________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: (MM/DD/YY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

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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 Anthem program.
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. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

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 misrepresentation 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.

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

FRAUD NOTICE: Any person who, with intent to defraud or knowing that he 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.

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 (MM/DD/YYYY)
X	

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Social Security no.* (required)

Section 8: Waiver/Declining coverage

Medical coverage

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

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental coverage

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

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

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