

Employee Change Form Application



Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections. Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing www.anthem.com. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

1. Employer/Group Use:									
Employer Name and Address: _____									
Group #		Sub-group #/Life Division #		Request Effective Date		Life Classification		Applicant #/Dept. name	
Anthem use:									
Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)		
/ /	/ /	/ /	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		
2. Reason for Change									
Event date ____/____/____ <input type="checkbox"/> Address <input type="checkbox"/> Change Life Beneficiary <input type="checkbox"/> Cancel/Waiving Coverage (Refer to section 9) <input type="checkbox"/> PCP change <input type="checkbox"/> Name change									
<input type="checkbox"/> Change Life Classification <input type="checkbox"/> Enrollment in Medicare (see section 7) <input type="checkbox"/> Conversion <input type="checkbox"/> Benefit change <input type="checkbox"/> Cancel dependent <input type="checkbox"/> Other _____									
3. Type of Coverage/Plan									
Health Coverage				Dental Coverage			Vision Coverage		Life Coverage
<input type="checkbox"/> HMO* ₁ <input type="checkbox"/> POS* <input type="checkbox"/> PPO _____ <input type="checkbox"/> Blue Traditional® <input type="checkbox"/> Anthem Essential SM PPO <input type="checkbox"/> Blue Priority SM * ₁ (1Ohio only-a health insuring corporation product or "HIC") <input type="checkbox"/> Blue Access SM Hospital Surgical PPO <input type="checkbox"/> Lumenos® Health Savings Account <input type="checkbox"/> Lumenos® Health Reimbursement Account <input type="checkbox"/> Lumenos® Health Incentive Account <input type="checkbox"/> Lumenos® Health Incentive Account Plus <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage				<input type="checkbox"/> PPO <input type="checkbox"/> Traditional (Indiana and Ohio only) <input type="checkbox"/> Dental Blue® <input type="checkbox"/> Dental Blue® 100 <input type="checkbox"/> Dental Blue® 100/200/300 <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage			<input type="checkbox"/> Vision <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage		<input type="checkbox"/> Life (see section 6)
Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.									
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 <i>the financial custodian</i> , the custodian of my Health Savings Account (HSA), I understand that my authorization is required before <i>the financial custodian</i> may provide Anthem Blue Cross and Blue Shield with information regarding my HSA. I hereby authorize <i>the financial custodian</i> to provide Anthem Blue Cross and 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 and Blue Shield with a written request to revoke my authorization at any time.									
4. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. (SS# required)									
Last name		First name, M.I.		Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	Height	Weight
/ /		- - -		- - -		- - -			
Home address			City	State	Zip code	County			
Hours worked per week		Anthem PCP name and address*				Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If PCP is a change, please indicate the reason for the change.									
5. Family Information Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. (SS# required for spouse/domestic partner)									
1 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name			First name, M.I.				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change				
/ /		- - -							
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)									
Anthem PCP name and address*					Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name			First name, M.I.				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change				
/ /		- - -							
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)									
Anthem PCP name and address*					Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name			First name, M.I.				
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change				
/ /		- - -							
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)									
Anthem PCP name and address*					Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

6. Life and Disability Insurance

Basic Life Basic AD&D Short Term Disability _____% Anthem By Design Short Term Disability BUY-UP
 Dependent Life Optional AD&D Long Term Disability _____% Anthem By Design Long Term Disability BUY-UP
 Optional Life: _____ x annual earnings OR \$ _____ Anthem By Design Basic Life BUY-UP
 Current Income: \$ _____ Hour Week Month Year (Complete separate election form.)

Are you currently active at work? Yes No
If no, reason: _____

<i>Primary Beneficiary</i>	Last Name	First Name, M.I.	Social Security # - -	Relationship to applicant	Age
<i>Contingent Beneficiary</i>	Last Name	First Name, M.I.	Social Security # - -	Relationship to applicant	Age

7. Other Health Coverage Please check one: YES (complete below) NO

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company	Policy/certificate number	Effective date / /	
Policy/certificate holder's name	Social security number - -	Date of birth / /	Relationship to applicant

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /	

Reason for Medicare entitlement: Age Disability ESRD & Disability End Stage Renal Disease (ESRD)

8. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

- I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
- I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
- I am applying for the coverage selected on this application. If I select a coverage, or 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.
- I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
- I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself. I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Applicant Signature	Date / /
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9. Waiver of coverage for employee and/or any eligible dependent not enrolling

Check all that apply. Waiving: Health Dental Vision Life All

Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)

Check all that apply. Waiving: Health Dental Vision Life All

Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)

Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
<p>Check all that apply <input type="checkbox"/> I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a member who is enrolled in the plan prior to his/her 19th Birthday. 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 dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption. I also understand that my dependents and I may enroll under two additional circumstances:</p> <ul style="list-style-type: none"> • 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) <p>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.</p> <p><input type="checkbox"/> I certify that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, 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.</p>	
Applicant signature	Date / /

Life and disability products are underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of: Anthem Insurance Companies, Inc. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.