Member Enrollment/Member Change Form

Anthem

TO BE COMPLETED BY EMPLOYER		
Firm division no.	Health benefit plan	Requested effective date

Section 1. SUBSCRIBER/APPLICANT INFORMATION

Current Anthem BCBS contract no., if any	Last name	First name	M.I.

Home address or P.O. box	City	State	ZIP code

Home telephone	Work telephone	Marital status
		☐ Single ☐ Legally separated ☐ Widowed ☐ Married ☐ Separated ☐ Divorced

Section 2. ENROLLMENT REASON

☐ New group (Initial enrollment) ☐ Annual enrollment ☐ New hire
☐ COBRA/CGS 38A-538: Reason _____ Qualifying event date _____

Section 3. CHANGE STATUS. PLEASE CHECK THE REASON(S) FOR CHANGE BELOW AND INDICATE DATE.

Type of change

☐ Name (indicate former name) _____ ☐ Address ☐ Other: Reason _____ Date _____

Section 4. MEMBERSHIP CHOICES

	Individual	Two person	Family
☐ Access Blue New England	☐	☐	☐
☐ BlueCare Plan name _____	☐	☐	☐
☐ Blue Choice New England	☐	☐	☐
☐ Century Preferred/PPO	☐	☐	☐
☐ Dental Plan name _____	☐	☐	☐
☐ HMO Blue New England	☐	☐	☐
☐ Lumenos HSA* Plan	☐	☐	☐
☐ Lumenos HRA Plan	☐	☐	☐
☐ Lumenos HIA Plan	☐	☐	☐
☐ Lumenos HIA Plus Plan	☐	☐	☐
☐ Blue View Vision Plan name _____	☐	☐	☐
☐ Other Plan name _____	☐	☐	☐

*Confirm with your employer which HSA custodian was selected.

Are you or any other eligible dependent listed on this form currently confined to a hospital or other health care facility, totally disabled or physically impaired?

☐ Yes ☐ No

Section 5. EMPLOYER INFORMATION

Company name

Are you actively at work?	Are you currently claiming Workers' Comp medical benefits?
☐ Yes ☐ No If no, reason: ☐ Sick ☐ Injured ☐ Other _____	☐ Yes ☐ No

Date of full-time hire*	Date of part-time hire*	Date of rehire* (if applicable)	Do you work 30 or more hours per week?
			☐ Yes ☐ No Hours _____

*Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

Section 6. APPLICANT AND MEMBER INFORMATION (LIST ONLY FAMILY MEMBERS YOU WISH TO ADD OR CANCEL)

Add	Cancel	Vision	Name(s) of person(s) (Last name, first name, M.I.)	Sex	Birthdate (MM/DD/YYYY)	Full-time student age 19 or over?	Name of recognized institution for full-time students	Primary Care Physician (PCP) Name (Refer to Provider Directory or anthem.com) Put an X the box ☐ if you currently use this physician
☐	☐	☐	Self SSN	☐ M ☐ F				Name City ☐ PCP no.
☐	☐	☐	☐ Legal spouse ☐ Domestic partner SSN	☐ M ☐ F				Name City ☐ PCP no.
Children up to age 26 may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.								
☐	☐	☐	Dependent SSN	☐ M ☐ F		☐ Yes ☐ No		Name City ☐ PCP no.
☐	☐	☐	Dependent SSN	☐ M ☐ F		☐ Yes ☐ No		Name City ☐ PCP no.
☐	☐	☐	Dependent SSN	☐ M ☐ F		☐ Yes ☐ No		Name City ☐ PCP no.

Section 7. PRIOR COVERAGE INFORMATION - THIS SECTION MUST BE COMPLETED.

Do you or any other member of your family have any other medical, dental, or Anthem Blue Cross and Blue Shield coverage?
☐ Yes ☐ No **If yes, please complete the following:**

	Self	Spouse/Domestic partner	Dependents 1	2	3
Name of insurance company					
Certificate (policy) no.					
First and last date of coverage					
Reason for termination					

Section 8. MEDICARE/MEDICAID INFORMATION

Do you or any covered member have Medicare/Medicaid coverage?
☐ Yes ☐ No

Have you or any covered member applied for Medicare/Medicaid disability?
☐ Yes ☐ No

Name(s) of Medicare Beneficiaries	Are you actively at work?	Retirement date (MM/DD/YYYY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date

Section 9. APPLICANT SIGNATURE

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

Applicant signature	Print name	Date
X		

INSTRUCTIONS (PLEASE PRINT ALL INFORMATION.)

Thank you for choosing our plan.
Please read these instructions before filling out the attached Enrollment and Membership Change Form. Here's what you need to fill out, so we can enroll you without delay.

For new enrollment, complete all sections.

For membership changes, complete:

Section 1. SUBSCRIBER/APPLICANT INFORMATION.

Section 3. CHANGE STATUS.

In addition, when adding/cancelling eligible dependents, or changing a Primary Care Physician (PCP), complete:

Section 6. APPLICANT AND MEMBER INFORMATION.

Section 7. PRIOR COVERAGE INFORMATION.

Section 8. MEDICARE/MEDICAID INFORMATION.

Section 1. SUBSCRIBER/APPLICANT INFORMATION

Please complete all information in this section.

Section 2. ENROLLMENT REASON

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a-538 extension of coverage member, please indicate the date of the Qualifying event, and also the Reason code.

Reason code	Qualifying event	Reason code	Qualifying event
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

Section 3. CHANGE STATUS

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:
Address Adoption Birth Dependent Divorced Legally Separated Married Name PCP

Section 4. MEMBERSHIP CHOICES

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice(s). If you choose "BlueCare", "Dental", "Blue View Vision", or "other", please be sure to write the name of the plan as instructed by your Benefits Coordinator.

B. Please check individual, two person or family for each plan choice.

Section 5. EMPLOYER INFORMATION

Please complete all information in this section.

Section 6. APPLICANT AND MEMBER INFORMATION

A. Please be sure to complete all information in this section including social security numbers, and the name(s) of recognized institution(s) for full time student dependent(s) age 19 or over if required by your employer's guidelines for eligibility.

B. Indicate last name if different.

C. If any dependent(s) listed are disabled, please circle that dependent, and attach the appropriate application which may be obtained from your Benefits Coordinator.

D. Special instructions for BlueCare. A Primary Care Physician (PCP) must be selected for each member. Each member may choose a different PCP. Specialists cannot be selected as PCPs. Please also write in the city or town where the PCP's office is located, and the PCP provider number, located in your Provider Directory.

An asterisk (*) next to a Physician's name in the provider listing means the physician can only be seen by a current patient. If you are a current patient and want that physician to be your PCP, please check the box next to the physician's name on the application.

E. If coverage is available through your employer's plan for domestic partnerships, please include the appropriate certification forms.

Section 7. PRIOR COVERAGE INFORMATION

Please be sure to note any other insurance information in this section.

Section 8. MEDICARE/MEDICAID INFORMATION

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare or Medicaid disability.

Section 9. APPLICANT SIGNATURE

Application will not be considered valid if unsigned. Please sign and return the completed application to your employer's Benefits Coordinator. Save your copy of this form for your records until you receive your identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.

DEFINITIONS

The definitions listed below are for informational purposes only. For additional information, please refer to your Master Group Policy, Subscriber Agreement, or the Evidence of Coverage.

ELIGIBLE EMPLOYEE: An Eligible Employee is defined as a full-time employee of the employer. In order to qualify as a full-time employee, the employee must be actively at work and working at least 30 hours per week on a regularly scheduled basis unless a higher number of hours per week is required by the employer. Part-time employees must work at least 20 hours per week. (Part-time coverage may not be offered by all employers.) Temporary employees and seasonal employees are not eligible for coverage.

ELIGIBLE DEPENDENTS:

a. An Eligible Employee's spouse under a legally valid existing marriage.

b. For insured accounts: A child* of an Eligible Employee up to age 26 if the child meets Anthem's guidelines for dependent eligibility under federal and state law. Please check with Anthem regarding those guidelines.

c. For self-insured accounts: A child* up to age 26 who meets your employer's guidelines for eligibility. Please check with your employer regarding those guidelines.

EXCEPTION FOR NEWBORN: Newborn children are automatically entitled to coverage for the first 31 days following birth. If no additional premium is due Anthem BCBS, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within a reasonable amount of time following birth in order to continue coverage without interruption. *If additional premium is required, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within 31 days following birth in order for coverage to be continued without interruption.*

LATE ENROLLEE: An Eligible Employee and/or dependent who requests insurance more than 31 days after the employee's earliest opportunity to enroll for coverage under any plan sponsored by the Employer may be considered a late enrollee. A Late Enrollee will be subject to a 12 month pre-existing condition waiting period for indemnity/PPO plans, or a 3 month affiliation period for HMO plans. Late Enrollees who are eligible for coverage will not be denied coverage, and completion of a statement of health form may be required. An Eligible Employee and/or dependent will not be considered a Late Enrollee, if a request for coverage is made and all of the following conditions satisfied: (1) Coverage was not elected when the employee was first eligible under the group policy solely because another group health insurance plan provided coverage for the employee; and (2) Coverage is lost under that plan due to employment termination, death of a spouse, divorce, legal separation, loss of eligibility, COBRA benefit is exhausted, reduction in the number of work hours for employment, or the employer stops contributing to the health benefit plan; and (3) The employee applies for coverage under this contract within 31 days after loss of coverage under the other plan.

ACTIVELY AT WORK: The term Actively At Work means the employee must: work at the employer group's place of business or at such place(s) as normal business requires; and perform all the duties of the job as required of a full-time employee working the minimum number of hours per week on a regularly scheduled basis.

DATE OF HIRE/REHIRE: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

WAITING PERIOD: Means a period of time that must pass before an employee or a dependent is eligible to enroll in the plan. The Anthem BCBS standard waiting period allows for new hires to be eligible to enroll for coverage following 30 days of continuous "actively at work employment." Generally new hires and their dependents who apply for coverage more than 31 days from the date first eligible will be considered a Late Enrollee.

EFFECTIVE DATES: New hires and their dependents will be effective the first of the month following completion of the waiting period. Effective dates for new hires may be deferred if all required information is not received, or is incomplete.

PRE-EXISTING CONDITION: *(Required for Small Employer Groups 1-50)* The term Pre-Existing Condition means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, care, or treatment was recommended or received within the Pre-Existing Condition Period as specified in the Schedule of Benefits.**

PRE-EXISTING CONDITION PERIOD: A period of time immediately prior to the effective date of coverage.**

AFFILIATION PERIOD: Means a period of time that must expire before health coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits. No premium shall be collected for such period.

BENEFITS EXCLUSION PERIOD: A period of time during which no benefits will be provided for a pre-existing condition. Prior creditable coverage can reduce the length of a benefit exclusion period. We will request a certificate of prior creditable coverage from you regarding your previous health plan if necessary.

OPEN ENROLLMENT PERIOD: The term open enrollment means the period of time during which an employer group allows employees to select group health coverage.

* "Child" includes a natural child, a legally adopted child or a child legally placed for adoption, a step-child, a child supported by the employee pursuant to a valid court order, or a child for whom the employee is legal guardian.

**These provisions are not applicable to HMO products.