Employee Enrollment Application
For 1–50 Employee Small Groups[1]
Connecticut

Anthem BlueCross BlueShield

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 in black ink only.

Section A: Application Type — Select one.

☒ New enrollment
☐ Open enrollment
☐ Rehire — Rehire date:

☐ COBRA —
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

Qualifying event date:

Court-ordered health care coverage? ☐ Yes ☒ No If yes, attach legal documentation.

Section B: Employee and Dependent Information — All fields required. Attach a separate sheet if necessary.

Employee last name	First name	M.I.	Social Security no.[2] (required)

Home address — Street and P.O. Box if applicable		

City	State	ZIP code

Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Secondary phone no.

Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self

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

Employee email address	Income reported by: ☒ W-2 ☐ 1099 ☐ Other: _____

Employer name	Group no. (if known)

Employer street address		

City	State	ZIP code

Employment status ☒ Full time ☐ Part time ☐ Disabled ☐ Retired	Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week 30+

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.[2] (required)

Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No

1 A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.
2 Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Section B: Employee and Dependent Information — Continued. All fields required. Attach a separate sheet if necessary.

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

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

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

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

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

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

Section C: Type of Coverage

1. **Medical Coverage — Select one plan option. Dental coverage for children under age 21 is already included in all our medical plans (also known as Pediatric Essential Health Benefits).**

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Century Preferred	☐ (2H8G) 30/0%/3000	☐ (2H9N) 1000/20%/5500 ☐ (2H7K) 1500/20%/3000 ☐ (2HAE) 2000/0%/3500 ☐ (2HAJ) 2000/0%/4900 ☐ (2H8J) 2500/0%/5000 ☐ (2HBZ) 2500/20%/4600 ☐ (2HAA) Tiered 2000/0%/5500	☐ (2H7S) 2500/20%/6500 ☐ (2HB4) 3000/20%/6750 ☐ (2H7V) 3500/30%/5500 ☐ (2H9J) 3550/20%/7150 ☐ (2HAW) 4500/0%/6000 ☐ (2H99) 2700/25%/5000 w/HSA ☐ (2H9E) 3000/0%/5000 w/HSA ☐ (2HA2) Tiered 2750/0%/6000 w/HSA	☐ (2H8V) 5500/20%/6550 w/HSA
HMO Plans	**Anthem Platinum**	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
BlueCare	☐ (2H8C) 30/0%/3000 ☐ (2H9S) Tiered 20/0%/6600	☐ (2H80) 2750/0%/4000 ☐ (2HA6) Tiered 2000/0%/5500		

Member medical coverage — select one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

1 Anthem is required by the Internal Revenue Service to collect this information.

2. Dental Coverage — Please ask your employer which dental options are available before checking your selection.

Anthem Family Dental and Anthem Family Dental Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits. Your employer will advise you of your plan options. Please list below the contract code for the dental plan you select.

Member dental coverage — select one:

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

If waiving coverage for employee and/or any eligible family members, you must complete Section E.

Contract Code — Please indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Contract code: _____

3. Vision Coverage — Select one plan option.

Member vision coverage — select one:

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

If waiving coverage for employee and/or any eligible family members, you must complete Section E.

Contract code — Please indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Contract code: _____

Section D: Other Group Coverage — Attach a separate sheet if necessary.

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

If yes, give name: _____

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

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare? ☐ Yes ☒ No

On the day your coverage begins, will you or a family member be covered by other health coverage? ☐ Yes ☒ No

On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☒ No

If yes to any of these questions, 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.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Section E: Waiver/Declining Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

☐ Covered by spouse's/domestic partner'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			

Section F: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem Blue Cross and Blue Shield (Anthem) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the renewal date of the group when the child reaches age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself by reason of mental or physical handicap, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

Section F: Terms, Conditions and Authorizations — Continued

In signing this application I represent that:

I have read or have had read to me the completed application, and I understand that intentionally false and/or intentionally 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.

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

By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

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 or by another carrier.

For insurance entities, the term "medical loss ratio"(MLR) refers to the ratio of incurred claims to earned premium for a prior calendar year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2013, Anthem's Medical Loss Ratio for state law purposes was 81.6% for HMO plans and 84.2% for PPO/Indemnity plans. For 2013, Anthem's MLR for federal law purposes was 85.9% for small group plans and 89.4% for large group plans. Please refer to anthem.com for the most current MLR information.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. You also understand that you and your dependents may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.