Employee Enrollment Application
For 1–50 Employee Small Groups
Indiana

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: Employee Information

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

Home address – Street and PO Box if applicable

City	County	State	ZIP code

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

Employee email address

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

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: ____________________

Do you read and write English?
☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment (not applicable for Life and Disability)

☐ 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

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse/Domestic Partner) 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. I also understand that my dependents and I may enroll under two additional circumstances:

- If 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.

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

Life and Disability products 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 registered marks of the Blue Cross and Blue Shield Association.

Employee name	Social Security no.

Section C: Type of Coverage

1. Medical Coverage — select one plan option:

Enter network selected: ______________________________

Enter product selected: ______________________________

Enter contract code selected: ______________________________

Member medical coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage — Please ask your employer which dental options are available before making 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 F.

Contract code — Please indicate the contract code for the dental plan chosen. 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 F.

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

Contract code: ____________________

Employee name	Social Security no.

4. Life and Disability Coverage — A minimum of two employees must enroll.

☐ Basic Life and AD&D
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and AD&D $ ___________ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse $ ___________ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child $ ___________ (child amount)

☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income	Life and Disability class no.

Primary Beneficiary — Attach a separate sheet if necessary.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 1-866-692-6901.

Spousal/Domestic Partner Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's/Domestic Partner's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse/Domestic Partner if your spouse/Domestic Partner will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse/ Domestic Partner read and sign the following. I am aware that my spouse/Domestic Partner, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date
X		

Employee name	Social Security no.

Section D: 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/domestic partner, or your children, or your spouse's/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.

Employee last name | First name | M.I.

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

Have you used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Spouse/Domestic Partner last name | First name | M.I. | Social Security no.[1] (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

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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: ____________________

Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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: ____________________

Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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: ____________________

Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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

Employee name	Social Security no.

Section E: 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	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:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Section F: 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)
***Life/AD&D** coverage declined for: ☐ Myself
Spouse, Domestic Partner and Dependent coverage not available if life coverage is waived/declined.
Dependent Life coverage declined for: ☐ Spouse/Domestic Partner and Dependents
Short Term Disability coverage declined for: ☐ Myself
Long Term Disability coverage declined for: ☐ Myself
Optional Supplemental/Voluntary coverage declined for: ☐ Myself
Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/Domestic Partner and Dependents
Voluntary Short Term Disability coverage declined for: ☐ Myself
Voluntary Long Term Disability coverage declined for: ☐ Myself

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

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, 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.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Today's date (MM/DD/YYYY)
X		

Employee name	Social Security no.

Section G: 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/Domestic Partner, 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 last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit.
- 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.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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

I understand that I may not assign any payment under my Anthem program. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.

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.

I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

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.

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

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.

Sign here	Applicant signature X	Today's date (MM/DD/YYYY)