Employee Change Form
For 1–50 Employee Small Groups
Indiana

Anthem BlueCross BlueShield AnthemLife

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing anthem.com. Also note that Life and Disability benefits are available for 2-50 Employee Small Groups.

Section A: General Information

Employer name	Group no.	Employee life class

Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

Section B: Employee Information – Required.

Reason for change – Required. Check all that apply.

☐ Address change ☐ Add spouse/domestic partner or dependent ☐ Change life classification ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/domestic partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other: _____

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.

☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Home address – Street and PO Box if applicable	City	State

ZIP code	County	Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner

Primary phone no.	Secondary phone no.	Email address

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

Section C: Family Information – Spouse/Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.

☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (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

Does the spouse/domestic partner have a different address? ☐ Yes ☐ No
If yes, please enter: _____

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

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

Reset Form Save and Print

Employee name	Social Security no.

Section C: Family Information — Continued.

☐ Add ☐ Change ☐ Cancel

Event reason — Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ____________________

Event date/Requested effective date – Required __________ (MM/DD/YYYY)

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

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

☐ Add ☐ Change ☐ Cancel

Event reason — Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ____________________

Event date/Requested effective date – Required __________ (MM/DD/YYYY)

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

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

☐ Add ☐ Change ☐ Cancel

Event reason — Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ____________________

Event date/Requested effective date – Required __________ (MM/DD/YYYY)

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

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

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

Employee name	Social Security no.

Section D: Plan/Type of Coverage

1. Medical Coverage

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

Note for Health Savings Account (HSA) enrollees:
If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one:

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

2. Dental Coverage

Product plan name	Contract code, if known

Member dental coverage – select one:

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

3. Vision Coverage

☐ I am enrolling in my Employer's vision plan, if any.	Contract code, if known

Member vision coverage – select one:

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

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.	Relationship	Social Security no.	Percentage

Contingent Beneficiary – Attach a separate sheet if necessary.

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Employee name	Social Security no.

Section E: Other Group Coverage

Is 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

Is anyone applying for coverage covered by other health coverage? ☐ 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.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:

Employee name	Social Security no.

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

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.

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	Date (MM/DD/YYYY)
	X	

Employee name	Social Security no.