Employer Enrollment Application
For 1–50 Employee Small Groups
Indiana

Please complete in black ink only.

Section A: Company Information

Company name			Employer tax ID no. (required)
Company street address			
City	County	State	ZIP code
Billing address – If different from above			
City	County	State	ZIP code

Is this for coverage as a member of an association plan? ☐ Yes ☐ No

If yes, association name: _____

Organization type:
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency
☐ Limited Liability Company (LLC) ☐ Labor union trust
☐ Other: _____

SIC code – Required	Type of business (be specific)	Date business established
Company contact name		Title
Primary phone no.	Fax no.	
Email address		
Additional company contact name		Title
Primary phone no.	Fax no.	
Email address		

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

_____

Open Enrollment

Our standard open enrollment period is at least 31 days before the Group's renewal date and 31 days after, which is held no more often than once in any 12 consecutive months.

Section B: Application Type

New group enrollment	Requested effective date (MM/DD/YYYY)

Reset Form Save and Print

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage – Check all that apply.

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Blue Access	☐ 0/10%/2250	☐ 1000/20%/3500 ☐ 1000/20%/5000 ☐ 1000/30%/4500 Plus ☐ 1350C/0%/2850 w/HSA ☐ 1350C/10%/2500 w/HSA ☐ 1500/20%/4000 ☐ 1500/30%/4500 ☐ 1750/0%/3425 Plus w/HSA ☐ 2000/0%/2500 w/HSA ☐ 2250/0%/2250 Plus w/HSA ☐ 2500/20%/5200 ☐ 3500/0%/4000 ☐ 3500/0%/4500 ☐ 500/20%/3500	☐ 2000/50%/6350 ☐ 2500/20%/6350 Plus ☐ 2600E/20%/4500 w/HSA ☐ 2600EC/0%/5400 w/HSA ☐ 2600EC/20%/5000 w/HSA ☐ 2600EC/30%/4500 Plus w/HSA ☐ 3000/20%/6250 Plus ☐ 3000/30%/7000 ☐ 3500E/0%/4500 w/HSA ☐ 3500E/0%/5250 w/HSA ☐ 4000E/0%/4700 w/HSA ☐ 4000/20%/7000 ☐ 4000E/0%/5000 w/HSA ☐ 5000/0%/6000 ☐ 5000/20%/6350 ☐ 5000/20%/6800 Plus ☐ 5000/30%/7150	☐ 5900/0%/7150 Plus ☐ 5950EC/0%/6550 w/HSA ☐ 6000E/20%/6550 w/HSA ☐ 6000EC/0%/6550 Plus w/HSA ☐ 6200EC/20%/6550 Plus w/HSA ☐ 6200EC/30%/6550 w/HSA ☐ 6200EC/30%/6550 w/HSA MO ☐ 6250E/0%/6550 w/HSA ☐ 6350E/0%/6350 w/HSA ☐ 6550E/0%/6550 w/HSA

Other: _____

Choose your medical contribution for each month – only **one** choice is allowed.

Contribution option 1: Traditional option – We will contribute (50% to 100%): _____% per employee _____% per dependent (optional).

Contribution option 2: Percentage of plan option – We will contribute: _____% to _____ plan)

For Health Savings Account (HSA) plans:

☐ Group will establish Health Savings Account (HSA) with Anthem Blue Cross and Blue Shield (Anthem) facilitating with a banking services provider.

☐ Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

HSA administrator name	Phone no.	Email address

Riders/Optional Benefits – Select additional optional benefits.

☐ Calendar Year ☐ Plan Year ☐ Bariatric surgery ☐ ChamberCare

Contract codes – Indicate the contract codes for the plan(s) selected. The codes can be found on the proposal/quote output.

Contract code	Contract code	Contract code
1.	4.	7.
2.	5.	8.
3.	6.	9.

Employer tax ID no. (required)

2. Dental Coverage

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. Please list below the contract code for the dental plan(s) you select.

Contract codes — Indicate the contract code(s) for the dental plan(s) chosen. The codes can be found on the proposal/quote output.
Contract code 1: _____ Contract code 2: _____ ☐ No dental coverage selected

Choose your dental contribution for each month:
_____% per employee _____% per dependent (optional)

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium ☐ Medical Lock premium ☐ Medical Lock and Bundled premium

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No
If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective date	Proposed termination date

Participation Requirements

Voluntary participation

5–50 Eligible Employees: A minimum of five employees must enroll (there is no participation-percentage requirement for our voluntary plans). Dual Option is not available for voluntary plans.

Value, Classic and Enhanced participation

2–4 Eligible Employees: 100% of eligible employees not covered by another dental plan minimum of two must enroll.

5–50 Eligible Employees: A minimum of 60% of employees not covered by another dental plan are required to enroll. A minimum of two must enroll.
For orthodontia, a minimum of 10 employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two plans and the two plans offered must have a 20% premium differential.

Medical Lock (Packaged Enrollment): Enrollment and tiering must be identical on both the Anthem medical and Anthem dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

3. Vision Coverage — Select one plan option.

☐ No vision coverage at this time.
☐ Employer-Sponsored Plans (available for groups with 2–50 employees, minimum of two subscribers must enroll).
☐ Voluntary Plans (available for groups with 5–50 employees, minimum of five subscribers must enroll).

Contract codes — Indicate the contract code for the vision plan chosen. The codes can be found on the proposal/quote output.
Contract code: _____

Choose your vision contribution for each month.
Employer-sponsored plans require employers to contribute between 50% and 100%.
For Voluntary plans employers may contribute between 0% and 49%.
We will contribute: _____% per employee _____% per dependent (optional).

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium ☐ Medical Lock premium ☐ Medical Lock and Bundled premium

Participation Requirements

Medical Lock (Packaged Enrollment) All members enrolled in an Anthem medical plan must enroll in Anthem vision. Tiering must be identical on the medical and vision plans. Example: enrollees with Single medical coverage must also have Single vision coverage; enrollees with Family medical coverage must also have Family vision coverage.

Employer tax ID no. (required)

4. Life and Disability Coverage – Check all that apply. A minimum of two employees must enroll.

Life products		Disability products	
Select Life products and group contribution percentage:		**Select Disability products and group contribution percentage:**	
Product choice	**Percentage**	**Product choice**	**Percentage**
☐ None		☐ None	
☐ Basic Life & AD&D	_____%	☐ Short Term Disability	_____%
☐ Basic Dependent Life	_____%	☐ Long Term Disability	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long Term Disability*	_____%
*Available for Groups of 10+		*Available for Groups of 10+	

Life and/or Disability Probationary Period/Waiting Period

Would you like to waive the probationary period/eligibility waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in Life and/or Disability plans after the group's coverage effective date the same as the Anthem medical policy eligibility period? ☐ Yes ☐ No

If no, enter the Life and Disability eligibility probationary period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

Prior Coverage

Has this group had life and/or disability coverage within 30 days of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name	Termination date
Life coverage ☐ Yes ☐ No		
Disability coverage ☐ Yes ☐ No		

Participation Requirements

Basic Life, Basic Accidental Death & Dismemberment, Short Term Disability: 100% participation required on non-contributory plans and 75% participation required on contributory plans.

Long Term Disability: 100% participation required on all non-contributory plans. 100% participation required for contributory plans of two or three eligible employees. 75% participation required on contributory plans with four or more eligible employees.

Basic Dependent Life: 100% participation required on non-contributory plans.

Optional/Voluntary Life/Accidental Death & Dismemberment: The greater of five enrolled employees or 20% participation required.

Voluntary Short Term Disability and Voluntary Long Term Disability: The greater of 10 enrolled employees or 20% participation required.

Employer tax ID no. (required)

Section D: Eligibility

1. Total number of employees (including employed owners/officers):
2. Number of eligible full-time employees (minimum 30 hours per week):
3. Number of employees enrolling in:
   - Medical:
   - Dental:
   - Vision:
   - Life/Disability:
4. Number of eligible DECLINING employees:
5. Number of INELIGIBLE employees (part time/seasonal):
6. Probationary period/waiting period for **new employees**:

   ☐ None ☐ First of month after hire date ☐ 1 month
   ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days

7. New eligible enrollees will become effective on:

   ☐ First of month following completion of waiting period/probationary period

   ☐ Day following completion of waiting period/probationary periods (required for 90 day waiting period)

   The standard effective date is first of the month following the waiting period/probationary period.

8. Employees currently in their waiting period will have coverage effective:

   ☐ On group's effective date

   ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

9. Probationary period/waiting period for **rehire employees**:

   If re-hire date is within 63 days of lay off, employee will be effective the date of re-hire. If more than a 63 day lapse the employee must serve the group's probationary period.

10. Under the Medicare Secondary Payer rules, which one applies for your group?

    ☐ Medicare is primary (less than 20 employees)

    ☐ Anthem is primary (20 or more employees)

    Anthem is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

11. Is your company currently subject to COBRA (employed 20 or more total employees on at least 50% of the working days in the previous calendar year)? ☐ Yes ☐ No

12. Do you have a COBRA administrator? ☐ Yes ☐ No

    Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No
    If yes, please complete and sign the COBRA agreement.

Employer tax ID no. (required)

Section E: General Agreement

Please read this section carefully before signing the application.

Please check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums, and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life Insurance Company trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem (herein to mean collectively, and separately, Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company) or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual.
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week (25 in OH if the employer is a "small employer" as defined by Ohio law, or if employer participates in a trust to which a group policy has been issued which contains a minimum 25 hours per week eligibility requirement), must be actively at work, must have satisfied any applicable eligible waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
18. This small group off-exchange product is not eligible for a premium tax credit.
19. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits.

Fraud Notice

Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Sign here	Company officer signature **X**	Title	
	Printed name		Date (MM/DD/YYYY)
Accepted by Anthem Blue Cross and Blue Shield and/or Anthem Life authorized representative		Printed name	Today's date (MM/DD/YYYY)

Employer tax ID no. (required)

Section F: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem reviews and approves the application and the employer receives a written notice from Anthem.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			**%**	**Second writing payable/sub-agent/producer/broker (Second writing agent not applicable in Maine and Virginia)**			**%**
Agency name	Agency ID no.			Agency name	Agency ID no.		
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. if different			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature	Today's date (MM/DD/YYYY)			Signature	Today's date (MM/DD/YYYY)		

For General Agent/Producer/Broker use only

General agent/producer/broker name	Agent/producer/broker ID no.		
Street address	City	State	ZIP code

Sales Representative and Account Manager

Sales representative name	Sales representative ID no.		
Street address	City	State	ZIP code
Account manager name	Account manager ID no.		

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)

Employer tax ID no. (required)