

Employee Enrollment Application



Group size 51+ eligible employees

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.



**Your Anthem enrollment application is inside.
It is essential that you read it carefully and
complete all the necessary sections.**

If you are a new enrollee:

- a) applying for health, vision and/or dental coverage plus life and disability insurance, please complete sections 2, 4, 5, 6, 7, 8, 9, and 10. Your signature is required in Section 10. (Vision currently unavailable in MO)
- b) applying for health, vision and/or dental coverage but waiving life and disability insurance, please complete sections 2, 4, 5, 6, 8, 9, 10, and 11. Your signature is required in Section 10. (Vision currently unavailable in MO)
- c) applying for life and disability insurance but waiving health coverage, please complete sections 2, 5, 6, 7, 10 and 11. Your signature is required in Section 10.
- d) waiving all coverage, please complete sections 2, 5, and 11. Your signature is required in Section 11.

If you are adding a dependent(s),
complete section 3 in addition to the above.

If you are a new enrollee in Anthem ByDesign Buy-up Coverage:

Applying for Anthem ByDesign Buy-up Health, Dental or Vision coverage, please complete the appropriate PPO check box under section 4 "Type of Coverage/Plan" and write in the Health, Dental or Vision plan number of the benefit you have selected on the line provided next to the PPO check box. (Vision currently unavailable in MO)

Applying for Anthem ByDesign Buy-up Short Term Disability (STD) or Long Term Disability (LTD) coverage, please complete the STD or LTD check box under section 7 "Life and Disability Insurance" and write in the benefit percentage you have selected on the line provided next to STD or LTD.

**It is important that you read and understand
the Significant Terms, Conditions and
Authorizations in Section 10.**

***Thanks for choosing Anthem
Blue Cross and Blue Shield.***

www.anthem.com

Note: You may be required to supply
additional information.

Anthem Blue Cross and Blue Shield is the trade name RightCHOICE Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC).
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Please complete in blue or black ink and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com

1. Employer/Group Use: Employer Name and Address:											
Group #		Sub-group #/ Life Division #		Request. Effective Date / /		Life Classification		Applicant #/Dept. name			
Anthem use:	Plan	Health Effective Date / /		Life Effective Date / /		Dental Effective Date / /		PCP <input type="checkbox"/> Yes <input type="checkbox"/> No	COB <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-ex (date) / /	
2. Reason for Application					4. Type of Coverage/Plan						
<input type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment (N/A to Life) <input type="checkbox"/> COBRA Qualifying event _____ Event date ____/____/____					<input type="checkbox"/> Waiver (See Section 11) <input type="checkbox"/> New hire Rehire (date) ____/____/____ <input type="checkbox"/> Add dependent (see section 3)						
3. Status Change/Event					Health Coverage <input type="checkbox"/> HMO* <input type="checkbox"/> POS* <input type="checkbox"/> PPO _____ <input type="checkbox"/> Blue Access SM Choice Hospital Surgical <input type="checkbox"/> Lumenos SM Health Savings Account <input type="checkbox"/> Lumenos SM Health Reimbursement Account <input type="checkbox"/> Lumenos SM Health Incentive Account <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage Do you have, or are you establishing a Health Savings Account? <input type="checkbox"/> Yes <input type="checkbox"/> No Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.						
Event date ____/____/____ <input type="checkbox"/> Adoption* <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Guardianship* <input type="checkbox"/> Birth <input type="checkbox"/> Termed Employment *Include legal documentation. <input type="checkbox"/> Other _____					Dental Coverage <input type="checkbox"/> PPO _____ <input type="checkbox"/> DentaBlue (PPO) <input type="checkbox"/> DentaBlue Select (PPO) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage						
5. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in Medical or Dental HMO or POS.											
Last name		First name, M.I.		Date of birth / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # (SS# required for Lumenos SM Health Savings Account)		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	Height	Weight
Home address			City		State	Zip code		County			
Home telephone ()			Business telephone ()			eMail Address					
Are you:	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation			Full time hire date / /	Hours working per week	Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____		
Anthem PCP name and address*						Anthem PCP ID number*			New patient?*		
									<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Family Information *Spouse and dependents to be covered (Attach a separate sheet if necessary)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.											
1 Last name		First name, M.I.		Relationship to applicant		<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)											
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -		Height	Weight	Court ordered health care coverage? Currently hospitalized or disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)			
Anthem PCP name and address*						Anthem PCP ID number*			New patient?*		
									<input type="checkbox"/> Yes <input type="checkbox"/> No		
2 Last name		First name, M.I.		Relationship to applicant		<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)											
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -		Height	Weight	Court ordered health care coverage? Currently hospitalized or disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)			
Anthem PCP name and address*						Anthem PCP ID number*			New patient?*		
									<input type="checkbox"/> Yes <input type="checkbox"/> No		
3 Last name		First name, M.I.		Relationship to applicant		<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)											
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -		Height	Weight	Court ordered health care coverage? Currently hospitalized or disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)			
Anthem PCP name and address*						Anthem PCP ID number*			New patient?*		
									<input type="checkbox"/> Yes <input type="checkbox"/> No		

7. Life and Disability Insurance					
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Anthem By Design Short Term Disability-BUY UP	Life Class	
<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP		
Optional Life: _____ x annual earnings OR \$ _____			<input type="checkbox"/> Anthem By Design Basic Life-BUY UP		
Current Income: \$ _____			(Complete separate election form)		
<input type="checkbox"/> Hour	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Year		
<i>Primary Beneficiary</i>	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
<i>Contingent Beneficiary</i>	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
8. Other Health Coverage <i>Please check one:</i> <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> NO					
On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.					
Provide name, phone number and address of the HMO or insurance company			Policy/certificate number	Effective date	
Policy/certificate holder's name		Social Security number	Date of birth	Relationship to applicant	
If you and/or your dependents are enrolled in Medicare, complete the following.					
Enrollee's name(s)		Medicare ID#	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
			/ /	/ /	/ /
Medicare Part D ID#		Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date	
			/ /	/ /	
Reason for Medicare entitlement:					
<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD & Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)					
9. Prior Health Coverage <i>Please check one:</i> <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> NO					
Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No		Group name/ID#	Date policy in effect:		
Policy/Certificate #:			/ / — / /		
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No		List prior carrier(s)	Dates Policy in effect:		
			/ / — / /		
Please check the type of prior coverage					
<input type="checkbox"/> Employee <input type="checkbox"/> Employee / Spouse <input type="checkbox"/> Employee / Child(ren) <input type="checkbox"/> Employee / Spouse / Child(ren)					
Termination reason: <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of spouse <input type="checkbox"/> COBRA coverage exhausted <input type="checkbox"/> Employment terminated <input type="checkbox"/> Group plan terminated <input type="checkbox"/> Employer/group contribution ceased					
<input type="checkbox"/> Other:					

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
- I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
- I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
- I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company, which underwrites only life and disability coverages, may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Unless I applied for HMO/POS coverage, in which case there is no such exclusion.)
- I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
- By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by one of the following companies:

Healthy Alliance Life Insurance Company for PPO, HMO Missouri, Inc. for HMO, and for POS both Healthy Alliance Life Insurance Company and HMO Missouri, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section on page 3 carefully before signing. Please review your application for errors or omissions.	
By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.	
Applicant Signature	Date / /
11. Waiver of coverage for employee and / or any eligible dependent not enrolling	
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
<p>Check all that apply</p> <p><input type="checkbox"/> I represent that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.</p> <p>If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.</p> <p><input type="checkbox"/> I represent that I have been given an opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, 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.</p>	
Applicant Signature	Date / /