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

Anthem Blue Cross and Blue Shield | Anthem Life

Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem) and Anthem Life Insurance Company (Anthem Life), its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary. The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application.

Section A: Application Type

Select one:

☐ New enrollment ☐ Open enrollment (not applicable for Life and/or Disability products) ☐ COBRA ☐ Rehire date: (MM/DD/YYYY) ___/___/____

Select qualifying event (not applicable for Life and/or Disability)

☐ Covered employee's Medicare entitlement ☐ Death ☐ Left employment ☐ Loss of coverage
☐ Loss of dependent child status ☐ Medicare ☐ Reduction in hours

Qualifying event date: (MM/DD/YYYY) _____/_____/_____

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

Section B: Employee Information — All fields required.

Last name	First name	M.I.	Social Security no.[2] (required) - -

Home address — Street or P.O. Box if applicable	City	State	ZIP code

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

Employer name	Group no. (if known)

Employer street address	City	State	ZIP code

Employment status: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired	Occupation

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

Employee email address: _____

I'm providing my email address because **I, and my enrolled dependents, want to receive information about our benefits electronically**. These communications may include Identification (ID) Cards, Certificates of Coverage, billing invoices, Explanation of Benefits, Evidence of Insurability underwriting documents, required notices including cancellations and renewals, and helpful or specific personalized information to help get the most out of the benefits. I understand I need to register on anthem.com or the Anthem mobile app to get the most out of my plan's digital tools, and I will make sure Anthem and/or Anthem Life has my most up to date email address. I, and my enrolled dependents, understand that we can update our email addresses, communication preferences, and request free copies of any materials by going to anthem.com or calling the Member Services number on my ID card.

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

Section C: Type of Coverage

1. Medical Coverage — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.

Dental coverage for children under age 26 is already included in all our medical plans (also known as Pediatric Essential Health Benefits).

Medical product plan name:	Contract code, if known:

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

2. Dental Coverage — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Anthem Dental Prime, Anthem Dental Complete, and Anthem Essential Choice with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Dental 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 — Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Vision product plan name:	Contract code, if known:

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

4. Life, Accidental Death & Dismemberment (AD&D), and/or Disability Coverage

☐ Basic Life and AD&D ☐ Basic Dependent Life		☐ Short Term Disability
☐ Supplemental/Voluntary Life and AD&D	$ _____ (employee amount)	☐ Long Term Disability
☐ Supplemental/Voluntary Dependent Life Spouse	$ _____ (spouse amount)	☐ Voluntary Short Term Disability
☐ Supplemental/Voluntary Dependent Life Child	$ _____ (child amount)	☐ Voluntary Long Term Disability

Current annual income: $	Life and/or Disability class no.:

Beneficiary Designation — Attach a separate sheet if necessary.

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		
☐ Primary ☐ Contingent			- -		

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 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. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse 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 if your Spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse read and sign the following.

Authorization

I am aware that my Spouse, 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.

In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Sign here	**Spouse signature** X	**Spouse name** (print)	**Today's date (MM/DD/YYYY)** / /

Section D: Family Information — All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.

Employee Last name	First name	M.I.

Sex	Disabled	Birthdate (MM/DD/YYYY)
☐ Male ☐ Female	☐ Yes ☐ No	/ /

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

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

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

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

Dependent Child Last name	First name	M.I.	Social Security no.[2] (required)
			- -

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Child ☐ Other[3] 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 Child Last name	First name	M.I.	Social Security no.[2] (required)
			- -

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Child ☐ Other[3] 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: _____

2 Anthem is required by the Internal Revenue Service to collect this information.
3 Eligibility subject to Booklet or Certificate of Coverage.

Section E: Prior and Other Group Coverage — Attach a separate sheet if necessary.

Is anyone applying for coverage currently enrolled in Medicare? ☐ Yes ☐ No If yes, give name:____________________

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason (select all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease: Onset date (MM/DD/YYYY) ____/____/____

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	**Type (select one)**	**Coverage (select all that apply)**	**Insurer name**	**Policy ID no.**	**Dates (if applicable)** (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/_____ **End:** ____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/_____ **End:** ____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/_____ **End:** ____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/_____ **End:** ____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/_____ **End:** ____/_____/_____

Section F: Waiver/Declining Coverage — Proof of coverage will be required. (Proof of coverage not applicable for Life and/or Disability.)

Type of coverage/Declined for — Select all that apply.		**Reason for declining/refusing coverage** — Select all that apply.
☐ Employee	☐ Medical ☐ Dental ☐ Vision ☐ *Life/AD&D (Spouse/Domestic Partner and Dependent coverage not available if life coverage is waived/declined) ☐ Short Term Disability ☐ Long Term Disability	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by their employer's group coverage ☐ Enrolled in individual coverage ☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan: ____________________ ☐ Other — please explain: ____________________
☐ Spouse/ Domestic Partner	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life	
☐ Dependent(s)	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life List name of dependents to be waived: ____________________	

*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, to decline this coverage. I elect of my (our) own accord to decline this coverage. I understand that if I wish to apply for such coverage in the future, where permitted by law, I may be required to provide Evidence of Insurability at my expense.

Sign here only if you are declining coverage.

Sign here to decline	**Applicant signature** X	**Applicant name** (print)	**Today's date (MM/DD/YYYY)** / /

Section G: Terms and Conditions — 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/Anthem Life 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 (see Booklet or Certificate of Coverage for complete dependent eligibility terms)**:**

- 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 a child will end on the renewal date of the group when the child reaches age 26. For life coverage, only employee's Spouse/Domestic Partner or children age 26 or younger, legally adopted children, and stepchildren are eligible.
- 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 a mental or physical impairment 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 such mental or physical impairment 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.

Special Enrollment Rights for Medical Coverage Only (see Booklet or Certificate of Coverage for complete 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 or as noted in "Eligibility and Enrollment – Adding Members." 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.

Medical Loss Ratio (MLR)
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 2019, Anthem's Medical Loss Ratio for state law purposes was 86.74% for HMO plans and 80.89% for PPO/Indemnity plans. For 2020, Anthem's MLR for federal law purposes was 82.8% for small group plans and 91.8% for large group plans. Please refer to anthem.com for the most current MLR information.

Section H: Authorizations — Please read this section carefully and then sign below.

In signing this application I represent that:

- I have read, or have had read to me, the completed application. All statements and answers I have given on this application are true and complete to the best of my knowledge and belief. I realize that I may lose my insurance coverage if (1) I submit information on or with this application that is fraudulent, or (2) I intentionally make a material misrepresentation on the application, or (3) I intentionally omit material information in filling out the application. 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 am an eligible employee and I am requesting coverage for myself and all eligible dependents listed on this application.
- I certify each Social Security number listed on this application is correct.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I authorize my employer to deduct any required contributions for this insurance from my wages.
- I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and that I may provide Anthem with a written request to revoke my authorization at any time.

Authorization for applicants applying for Life and/or Disability coverage:

1. I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefit manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life Insurance Company (Anthem Life), consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, including information contained within Anthem Life or Anthem medical affiliates, to give any and all such information to authorized representatives of Anthem Life, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages if necessary for the required premium for the coverage for which I have applied.
4. This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.
5. I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner. I am acting as their agent and representative.

I understand a person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete or misleading information commits a crime; penalties may include imprisonment, fines or termination of and/or a denial of insurance benefits. I also understand all benefits are subject to conditions stated in the Group Contract and the Booklet or Certificate of Coverage.

I give this authorization for myself and on behalf of my eligible dependents, including my Spouse/Domestic Partner, if covered by Anthem and/or Anthem Life, and I am acting as their agent and representative. If my Spouse/Domestic Partner signs this application, he/she is giving this authorization on his/her own behalf.

Sign here to enroll	**Applicant signature** (or custodial parent's or guardian's signature if applicant is under 18) X	**Today's date (MM/DD/YYYY)** / /
	Spouse/Domestic Partner signature X	**Today's date (MM/DD/YYYY)** / /