Small Group Employee Enrollment Application

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. Please complete in black ink only.

Section A: Employer and Employee Information				
Employer name				
Employment status ☐ Full-time ☐ Part-time ☐ Retired	Date of hire (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /		
Employee home address — Street or P.O. Box if applicable	City	County	State	ZIP code
Primary phone no.		Employee email address		

I'm providing my email address because **I want to receive information about my benefits electronically.** These communications may include Identification (ID) Cards, Certificates of Coverage, billing invoices, Explanation of Benefits, 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 anthembluecross.com or the Anthem mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up to date email address. I understand that I can update my email addresses, change my communication preferences, and request free copies of any materials at any time by going to anthembluecross.com or calling the Member Services number on my ID card.

You must fill out the following section: Would you like to be added to the Donate Life Registry?
☐ **YES or** ☐ **SKIP THIS QUESTION**

Application type — Select one: ☐ New enrollment ☐ Open enrollment ☐ COBRA ☐ Rehire date (MM/DD/YYYY) _____/_____/_____

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other — please specify: _____

Select qualifying event for special enrollment by employee, spouse or dependent child.

☐ Mandatory Right of Election to continue Dependent coverage through age 29 (qualified dependents only)

Loss of coverage in other group plan due to:

☐ Loss of dependent child status
☐ Death of spouse
☐ Employer ends plan contributions
☐ Other group plan ends
☐ Reduction in hours
☐ COBRA/State continuation is exhausted
☐ Employment termination
☐ Legal separation, divorce or annulment
☐ Gain or become a dependent via marriage, birth or adoption
☐ Loss of or become eligible for Medicaid or Child Health Plus

Select qualifying event for COBRA:

☐ Death of subscriber
☐ Employment termination
☐ Employee becomes eligible for Medicare
☐ Reduction in hours
☐ Divorce or legal separation from subscriber
☐ Loss of dependent child status

Employee name:_____ Social Security no.:_____-_____-_____

Section B: Employee and Dependent Type of Coverage and Coverage Information — Complete this section for you and dependents to be covered. All fields required. Attach a separate sheet if necessary.				
Enrollee	**Employee/Subscriber**	**Spouse/Domestic Partner**	**Dependent***	**Dependent***
Social Secuity no.[1]	- -	- -	- -	- -
Birthdate (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Last name				
First name, Middle initial				
Gender	☐ Male ☐ Female ☐ Gender X	☐ Male ☐ Female ☐ Gender X	☐ Male ☐ Female ☐ Gender X	☐ Male ☐ Female ☐ Gender X
Check all that apply:		☐ Domestic Partner	☐ Young adult[2]	☐ Young adult[2]
*Enter dependent's address, if different:				
If your overage adult dependent is impaired, complete the NY Handicapped/Dependent Form (HAC 506), which can be found at https://www.anthembluecross.com/employer/forms/.				
Medical Coverage — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.				
Enrollee	**Employee/Subcriber**	**Spouse/Domestic Partner**	**Dependent**	**Dependent**
Medical contract code				
Enrollment status	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Primary Care Physician (PCP) name[3]				
PCP ID no.				
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Coverage				
Dental contract code				
Enrollment status	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Primary Care Dentist (PCD) name[3]				
PCD ID no.				
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision Coverage				
Vision contract code				
Enrollment status	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive

1 Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.
2 Your dependent between ages 26-30 may be covered if your employer has chosen this option or if you or your eligible dependent buy extended coverage through age 29.
3 To select a PCP and/or PCD, visit our website at www.anthembluecross.com/find-doctor. If your Anthem benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Employee name:_______________________________ Social Security no.:_____-_____-_____

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

Is anyone applying for coverage currently eligible for 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/D/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:** ____/_____/____

Employee name:_____ Social Security no.:_____-_____-_____

Section D: Terms, Conditions and Authorizations — Please read this section carefully before signing the application.

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 may result in loss of coverage. I certify each Social Security Number listed on this application is correct.

I understand that I am required to pay member cost share as required by my benefit plan.

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.

As an eligible employee, I request coverage for myself and eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in my employer's Group Contract and my Certificate of Coverage.

Special Enrollment Rights — Medical Coverage Only. If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other group health plan coverage, you can enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other group health plan due to any of the following: termination of employment; termination of the other group health plan; death of your Spouse; legal separation, divorce or annulment; reduction of hours of employment; employer contributions toward the group health plan were terminated; or a child no longer qualifies for coverage as a child under the other group health plan. You must request enrollment within 31 days after the other coverage ends (or after the employer contributions ends).

You may also enroll 31 days from the date your exhaust COBRA or state continuation coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) starting on the date of birth if you request enrollment within 60 days after the birth, adoption or placement for adoption. Otherwise, coverage begins on the date we receive notice of the birth or adoption, provided you pay additional premium when due.

If you get married while covered, you can add your Spouse effective on the date of your marriage if you tell us within 31 days. You, your Spouse or child can also enroll within 60 days of the occurrence of the following circumstances: You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

Health Savings Account: If you want to establish a Health Savings Account (HSA) with an HSA-compatible health plan, a bank needs to act as the HSA financial custodian. By signing below you hereby authorize the financial custodian to provide Anthem with information about your HSA, including account no., account balance and information about account activity. You may revoke this authorization at any time in writing.

INSURANCE FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign here	**Applicant signature** X	**Today's date (MM/DD/YYYY)** / /
	Company officer signature X	**Today's date (MM/DD/YYYY)** / /
	Printed name	**Group no.**