

# Employee Enrollment Application For 1-50 Employee Small Groups<sup>1</sup> Connecticut



Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem), its products and services, visit [anthem.com](http://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			
<b>Select one:</b>			
<input type="checkbox"/> New enrollment	<input type="checkbox"/> Open enrollment	<input type="checkbox"/> COBRA	<input type="checkbox"/> Rehire date: (MM/DD/YYYY) ___/___/___
<b>Select qualifying event</b>			
<input type="checkbox"/> Covered employee's Medicare entitlement	<input type="checkbox"/> Death	<input type="checkbox"/> Left employment	<input type="checkbox"/> Loss of coverage
<input type="checkbox"/> Loss of dependent child status	<input type="checkbox"/> Medicare	<input type="checkbox"/> Reduction in hours	
<b>Qualifying event date:</b> (MM/DD/YYYY) ___/___/___			
Court-ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, attach legal documentation.			
Section B: Employee Information — All fields required.			
Last name		First name	M.I.
Home address — Street or P.O. Box if applicable		City	State
			ZIP code
County	Primary phone no.	Marital Status	
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
Employer name		Group no. (if known)	
Employer street address		City	State
			ZIP code
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Disabled <input type="checkbox"/> Part-time <input type="checkbox"/> 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 <b>I, and my enrolled dependents, want to receive information about our benefits electronically.</b> 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 <a href="http://anthem.com">anthem.com</a> 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, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to <a href="http://anthem.com">anthem.com</a> or calling the Member Services number on my ID card.			
Section C: Type of Coverage			
<b>1. Medical Coverage</b> — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.			
<b>Dental coverage for children under age 26 is already included in all our medical plans (also known as Pediatric Essential Health Benefits).</b>			
Medical product plan name:		Contract code, if known:	
<b>Member medical coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family			

<sup>1</sup> A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.

<sup>2</sup> Anthem is required by the Internal Revenue Service to collect this information.

<b>2. Dental Coverage</b> — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.					
<b>Anthem Dental Prime, and 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.</b>					
Dental product plan name:			Contract code, if known:		
<b>Member dental coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family					
<b>3. Vision Coverage</b> — 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:		
<b>Member vision coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family					
<b>Section D: Family Information</b> — All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.					
<b>Employee</b> Last name			First name		M.I.
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /			
Primary Care Physician (PCP) name		PCP ID no.		Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Spouse/Domestic Partner</b> Last name			First name		M.I. Social Security no. <sup>2</sup> (required) - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
PCP name		PCP ID no.		Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Dependent Child</b> Last name			First name		M.I. Social Security no. <sup>2</sup> (required) - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other <sup>3</sup> If other, what is relationship? _____	
PCP name		PCP ID no.		Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____					
<b>Dependent Child</b> Last name			First name		M.I. Social Security no. <sup>2</sup> (required) - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other <sup>3</sup> If other, what is relationship? _____	
PCP name		PCP ID no.		Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> 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)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ___/___/___ End: ___/___/___
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ___/___/___ End: ___/___/___
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ___/___/___ End: ___/___/___
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ___/___/___ End: ___/___/___
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ___/___/___ End: ___/___/___

**Section F: Waiver/Declining Coverage** — Proof of coverage required.

<b>Type of coverage/Declined for</b> — Select all that apply.		<b>Reason for declining/refusing coverage</b> — Select all that apply.
<input type="checkbox"/> Employee	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> No coverage <input type="checkbox"/> Covered by Spouse's/Domestic Partner's group coverage <input type="checkbox"/> Spouse/Domestic Partner covered by their employer's group coverage <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Enrolled in other Insurance — Please provide company name and plan: _____ <input type="checkbox"/> Other — please explain: _____
<input type="checkbox"/> Spouse/ Domestic Partner	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
<input type="checkbox"/> Dependent(s)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision List name of dependents to be waived: _____	

Sign here **only** if you are **declining** coverage. **DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE.**

<b>Sign here to decline</b>	<b>Applicant signature</b> X	<b>Applicant name (print)</b>	<b>Today's date (MM/DD/YYYY)</b> / /
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**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 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 last day of the month in which the child reaches age 26.
- 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 because 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 91 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 91 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 2022, Anthem's Medical Loss Ratio for state law purposes was 84.44% for HMO plans and 86.70% for PPO/Indemnity plans. For 2022, Anthem's MLR for federal law purposes was 76.8% for small group plans and 93.2% for large group plans. Please refer to [anthem.com](http://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.

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 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.

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

# We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

## Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

## Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的ID卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

## Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

## Korean

귀하는 자국어로 무료 지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

## Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

## Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

## Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

## Farsi

"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

## French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

## Arabic

لك الحق في الحصول على مساعدة بلغتك مجاناً. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

## Japanese

お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

## Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

## Italian

Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

## Polish

Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

## Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

## TTY/TTD:711

## It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>