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

Anthem

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. Please complete electronically or in black ink only and use extra paper if necessary.

Section A: Application Type				
☐ New enrollment ☐ Change(s)	Requested effective date (MM/DD/YYYY): / /			
Section B: Company Information				
Legal company name	Employer tax ID (required)	Form 5500 ID number		
Doing Business As (DBA) (if applicable)				
Local (Physical) address	City	County	State	ZIP code
Billing address — If different from above	City		State	ZIP code
Organization type (Corporation (S or C), Partnership, Proprietorship, etc.): _____				
SIC code — required	Type of business (be specific)	Date business established (MM/DD/YYYY) / /		
Company contact name	Email address	Primary phone no.		
Additional company contact name		Email address		
Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No				
If you have ownership in another company, you may be considered a Single Employer with common ownership under IRS section 414, subsection (b), (c), (m), or (o). Do you qualify as a Single Employer with common ownership under IRS section 414? ☐ Yes ☐ No If yes, please complete below.				
Legal name	Federal tax ID no.	No. of employees employed		
Will any insurance carrier(s), in addition to Anthem, provide health coverage as part of the group's employee benefit plan? ☐ Yes ☐ No If yes, list carrier(s) and product(s) offered: _____				

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.

Employer tax ID no. (required): _____

Section C: Type of Coverage

1. Medical Coverage

Choose your medical contribution for each month — The minimum employer contribution is 25% of the lowest eligible employee rate. We will contribute _____% per employee (25% to 100%) and _____% per dependent (optional, may be from 0% to 100%).
Participation Requirements — If Employees contribute to the premium, then at least 75% of net eligible employees must enroll. If Employer pays 100% of premium, then 100% of net eligible employees must enroll. Participation requirements do not apply to Small Group Employer applications from November 15 - December 15.
For employers providing a Health Savings Account (HSA) option (only **one** choice is allowed)
Do you want Anthem to disclose your group's data to its banking services provider to establish Health Savings Accounts?
☐ Yes (Requires completion of the CDHP questionnaire) ☐ No

HSA administrator	Phone no.	Email address

Medical plans — Indicate the contract codes for the medical plan(s) selected. The codes can be found on the proposal/quote.

	Medical plan name	Medical contract code
Plan option 1		
Plan option 2		
Plan option 3		
Plan option 4		
Plan option 5		

Riders/Optional Benefits — Select additional benefits.

☐ Calendar Year ☐ Plan Year

2. Dental Coverage — Indicate the contract code(s) for the dental plan(s) selected. The codes can be found on the proposal/quote.

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.

Dental contract code 1: _____ Dental contract code 2: _____

Optional: Choose your dental contribution for each month. We will contribute: _____% per employee _____% per dependent

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ 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, EPO, PPO)	Effective date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)
		/ /	/ /
		/ /	/ /

3. Vision Coverage — Indicate the contract code for the vision plan selected. The codes can be found on the proposal/quote.

Vision contract code 1: _____ ☐ Employer-Sponsored Plans ☐ Voluntary Plans

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

Employer tax ID no. (required): _____

Section D: Eligibility

1. Average number of Full Time Equivalent (FTE) employees during the prior calendar year (including employed owners/officers: _____
2. Number of eligible full-time employees (minimum 30 hours per week): _____
3. Are part time employees to be covered (working 20 or more hours per week)? ☐ Yes ☐ No
4. Number of employees enrolling in:
   Medical: _____ Dental: _____
   Vision: _____
5. Number of eligible DECLINING employees: _____
6. Number of employees working outside of CT: _____
7. Total number of part-time employees based on the above small employer definition: Total calendar year hours worked by all part-time employees divided by 12 (the months in a calendar year) divided by 120 (the number of full-time hours in a typical month):
   _____
8. Probationary period/waiting period for **new employees:**
   ☐ None (Date of Hire[2]) ☐ 1 month ☐ 30 days
   ☐ 2 months ☐ 60 days ☐ 90 days
   Effective date for newly eligible employees[3]:
   ☐ First of month following completion of waiting period/ probationary period (not applicable for "90 days" option)
   ☐ Day following completion of waiting period/probationary periods (not applicable for "None (Date of Hire[2])" option)
9. Probationary period/waiting period for **rehire employees:** Coverage is reinstated back to the date of the loss of coverage if rehired within 31 days of the loss of employment. If re-hire date is within 92 days of lay-off or termination of employment, the probationary period will be waived and the employee's coverage will be effective the date of rehire. If the employee is hired back after 92 days, then the employee must serve the group's probationary period for new employees.
10. Do you wish to offer coverage for Domestic Partners?
    ☐ Yes ☐ No
11. Under the Medicare Secondary Payer rules, which one applies for you group for Medicare due to age?
    ☐ 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.
12. 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
13. Do you have a COBRA administrator? ☐ Yes ☐ No
14. Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No
    If yes, please complete and sign the COBRA agreement

Section E: Ownership — Please account for 100% of the ownership, regardless of eligibility. Attach a separate sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No

2 First day of active employment for pay.
3 Newly eligible employees include new employees and rehired employees. Newly eligible employees have 31 days from date of eligibility to enroll in coverage.

Employer tax ID no. (required): _____

Section F: Access of Group Information by Designated Agent/Producer/Broker/Agency/Brokerage/General Agency

We the employer hereby authorize our designated agent, producer, broker, agency, brokerage, general agency and their respective employees currently on file with Anthem (Agent) to access our health plan information, including protected health information, on behalf of our health plan through Anthem's EmployerAccess system or any other access points Anthem may offer. This information may include, but is not limited to, detail about members, plan selections and bills/invoices. Our Agent is also authorized to make changes to our information on our behalf, including but not limited to adding/deleting plans and members and changing member demographic information. We will be responsible for the activities of our Agent. If our Agent on file changes, these authorizations will apply with respect to our successor Agent. Our Agent is required to maintain all original documentation and will make such documentation available to Anthem upon request.

☐ Select this box **ONLY** if the employer DOES NOT want to authorize the agent/producer/broker/general agent to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

Section G: General Terms and Agreements — Please read this section carefully before signing the application. In this section, "Anthem" and "Company" refers to Anthem Blue Cross and Blue Shield.

Standard Open Enrollment for Employees: The standard open enrollment period is at least 31 days before the group's renewal date and 31 days after, no more often than once in any 12 consecutive months.

Please select 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 on this application. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

☐ 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 on this application.

We understand that this small group off-exchange product is not eligible for a premium tax credit.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Anthem will refund these premiums after 45 days from the premium deposit date.

For employers offering a Health Savings Account (HSA) compatible EPO plan: We, the employer, understand that the High Deductible EPO plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of pocket costs. We understand that having this coverage does not establish an HSA.

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. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

By signing below, I, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of non-payment and cancellation and other notices, via email or other electronic means. I agree that I will provide and update Anthem with a current email address. I understand that at any time I can request a free copy of these materials by mail or by contacting Anthem at 1-800-922-4770. I also agree that by providing Anthem with an employee or participant's email address, the employer thereby represents that: (1) the employer has the employee's consent to receive plan documents (including explanation of benefits and claim denials) electronically; (2) the employee has reasonable access to the electronic communication at work; and (3) the employer obtained the employee consent using Anthem's application form or in a manner that clearly and conspicuously described the types of communications which can be made electronically, any hardware or software required to access those communications, the ability and process to change email addresses or withdraw consent and request a paper copy or otherwise in a manner that complies with applicable state and federal law regarding electronic delivery of plan materials and adverse benefit determinations.
To the best of our knowledge and belief, all information on this application is true and complete, and Anthem may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Anthem. Any misstatements on the employees' applications may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem. We shall comply with all provisions of the contract(s) issued.

Employer tax ID no. (required): _____

The undersigned employer and/or authorized representative(s) agree:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable;
2. To make the insurance 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 the insurer or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. 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 the insurer;
5. That approval for this insurance may cancel any prior contracts and/or coverage with the insurer effective immediately preceding the effective date of the employer's coverage;
6. To pay the insurer 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;
7. Employer will receive, on behalf of members, all notices delivered by Company, and immediately forward such notices to persons involved, at their last known address;
8. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Company'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 Company except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
9. That in order for Company to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Company, 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 Company may be different than the coverage applied for herein. In that event, Company shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
10. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Company by the employer. Company reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
11. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Company in writing) and meet any other eligibility requirements for coverage;
12. The requested coverage is not in effect unless and until this application is approved by Company, that approval of coverage shall be evidenced by issuing insurance 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 Company.
13. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Sign here	**Company officer signature** X	**Title**	
	Printed name		**Today's date (MM/DD/YYYY)** / /
Accepted by Anthem authorized representative		**Printed name**	**Today's date (MM/DD/YYYY)** / /

Employer tax ID no. (required): _____

Section H: Agent Certification — In this section, "Anthem" refers to Anthem Blue Cross and Blue Shield.

1. I am not aware of any information not disclosed by the employer 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/producer/broker and am receiving commissions for the submission of this employer. No portion of my commission payments from Anthem shall be paid to an agent/producer/broker who is not appointed/approved by Anthem. I am licensed in the state of Connecticut for the types of insurance solicited.
6. I have advised the employer 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**			%
Agency name		Agency ID or TIN		Agency name		Agency ID or TIN	
Agent/producer/broker name				Agent/producer/broker name			
Payable/sub-agent/producer/broker Tax ID no. SSN if different				Payable/sub-agent/producer/broker Tax ID no. SSN if different			
Existing Broker EmployerAccess user name				Existing Broker EmployerAccess user name			
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 Tax ID no./SSN		
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.		

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