

Anthem Blue Cross Large Group Member Enrollment/Change Form



Anthem HealthChoice HMO, Inc. and/or Anthem HealthChoice Assurance, Inc. underwrite medical, dental, vision, group accident, specified disease and hospital indemnity insurance products.

Thank you for choosing Anthem Blue Cross (Anthem).

So that we may quickly and accurately process your enrollment, please complete in full and sign in section 7.

Section 1: Reason for enrollment/change — Please complete section A, B or C.

A. New enrollment/addition — Choose only one reason in bold.	
<input type="checkbox"/> New hire — Must indicate start date of full-time employment in section 8. Leave Date of change field blank. Date of change: _____ (MMDDYY)	
<input type="checkbox"/> Open enrollment — Leave Date of change field blank.	
<input type="checkbox"/> Status change — Select only one.	
<input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Retirement <input type="checkbox"/> Medicare eligible For Medicare eligible only, answer the following questions: Eligibility criteria — Select only one <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____ (MMDDYY) Active employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Electing company coverage as primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Electing Medicare-related coverage as primary coverage? . <input type="checkbox"/> Yes <input type="checkbox"/> No (If company size is under 20 employees and end-stage renal disease does not apply, you must choose this option)	
<input type="checkbox"/> Age 29 Adult Dependent Election — Must complete section 4.	
<input type="checkbox"/> Original COBRA/NYS Continuation of coverage: _____ (MMDDYY)	
Nature of COBRA/NYS event: _____	
<input type="checkbox"/> Loss of Coverage — Must indicate last day covered in section 6.	
You must fill out the following section: Would you like to be added to the Donate Life Registry? <input type="checkbox"/> YES or <input type="checkbox"/> SKIP THIS QUESTION	
B. Change — Check all that apply. For all checked boxes below, please supply new information in sections 4 and 5.	
<input type="checkbox"/> Name	Date of change: _____ (MMDDYY)
<input type="checkbox"/> Address	
C. Cancel coverage — Select only one.	
Note: If you are canceling your own coverage, please have your employer fill out a <i>Member Maintenance Change Form</i> . For other cancellations, please check the appropriate box below and enter the name in the Applicant and Family portion in section 5.	
<input type="checkbox"/> Spouse/Dependent <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent no longer eligible	Date of event: _____ (MMDDYY)
<input type="checkbox"/> Other: _____	

Section 2: Benefits Selection

Medical insurance — Select only one plan type.
Product/Plan: <input type="checkbox"/> PPO <input type="checkbox"/> Alt PPO <input type="checkbox"/> HRA
Other: _____
Select only one medical coverage type: <input type="checkbox"/> Individual <input type="checkbox"/> Employee/Spouse/Domestic Partner <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family
Dental insurance
<input type="checkbox"/> Anthem Dental
Select only one dental coverage type: <input type="checkbox"/> Individual <input type="checkbox"/> Employee/Spouse/Domestic Partner <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family
Vision insurance
Blue View VisionSM Included in PPO, Alt PPO and HRA

Section 3: Applicant information

Last name		First name		M.I.	Social Security no. ¹ (required)		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Date of birth (MMDDYY)	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married		Marriage date (MMDDYY)		
Street address						Apt. no.	
City					State	ZIP code	
Occupation			Primary language				
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, Contracts or 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 address, communication preferences, and request free copies of any materials by going to anthembluecross.com or calling the Member Services number on my ID card.							
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date	Part B coverage start date		
Medicare Part D ID no.		Medicare Part D carrier				Part D effective date	

Section 4: Family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets, if necessary.

To select a PCP and/or PCD, visit our website at anthembluecross.com and select **Find Care**. 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.

Applicant

Primary care physician (PCP) last name		PCP first name		PCP no.			
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Primary care dentist (PCD) last name		PCD first name		PCD no.			
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Spouse							
Last name		First name		M.I.	Social Security no. ¹ (required)		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Date of birth (MMDDYY)	Primary language, if different				
PCP last name		PCP first name		PCP no.			
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No							
PCD last name		PCD first name		PCD no.			
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Email address (requested for ages 18 and over): _____							
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date	Part B coverage start date		
Medicare Part D ID no.		Medicare Part D carrier				Part D effective date	

¹ Anthem is required by the Internal Revenue Service to collect this information.

Section 5: Family information — Continued.

Dependent 1						
Last name		First name		M.I.	Social Security no. ¹ (required)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Email address (requested for ages 18 and over): _____						
Relationship: <input type="checkbox"/> Child of applicant/spouse <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> Other If other, what relationship? _____						
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date		Part B coverage start date
Dependent 2						
Last name		First name		M.I.	Social Security no. ¹ (required)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.	
Current patient of PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Email address (requested for ages 18 and over): _____						
Relationship: <input type="checkbox"/> Child of applicant/spouse <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> Other If other, what relationship? _____						
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date		Part B coverage start date

¹ Anthem is required by the Internal Revenue Service to collect this information.

² Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.

³ Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 3						
Last name		First name		M.I.	Social Security no. ¹ (required)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Email address (requested for ages 18 and over): _____						
Relationship: <input type="checkbox"/> Child of applicant/spouse <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> Other If other, what relationship? _____						
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date	Part B coverage start date	
Dependent 4						
Last name		First name		M.I.	Social Security no. ¹ (required)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X		Date of birth (MMDDYY)	Primary language, if different			
PCP last name		PCP first name			PCP no.	
Current patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Email address (requested for ages 18 and over): _____						
Relationship: <input type="checkbox"/> Child of applicant/spouse <input type="checkbox"/> Full-time student ² <input type="checkbox"/> Disabled child ³ <input type="checkbox"/> Make available age 29 <u>adult</u> dependent child <input type="checkbox"/> Other If other, what relationship? _____						
Please provide a copy of the Medicare (HIB) card.		Medicare ID no.		Part A coverage start date	Part B coverage start date	

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

2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.

3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 6: Other medical coverage information — This section must be completed.

The questions in this section are for informational purposes only. The answers provided will have no bearing on eligibility.

Is anyone applying for coverage covered by other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following:					
Name(s) of person(s) (first, M.I., last)	Insurance company name	Coverage dates	Provided by employer?	Employment status	Contract type
Self	Carrier name	First day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Policyholder name				
	Phone	Last day covered			
	Certificate (policy no.)				
<input type="checkbox"/> Spouse	Carrier name	First day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Policyholder name				
	Phone	Last day covered			
	Certificate (policy no.)				
Dependent 1	Carrier name	First day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Policyholder name				
	Phone	Last day covered			
	Certificate (policy no.)				
Dependent 2	Carrier name	First day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Policyholder name				
	Phone	Last day covered			
	Certificate (policy no.)				
Dependent 3	Carrier name	First day covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> COBRA/NYS Continuation of coverage <input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
	Policyholder name				
	Phone	Last day covered			
	Certificate (policy no.)				

I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group's contract(s). I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent's, status; such change may result in a change of insurance status with Anthem and that failure to make such notification may result in cancellation of the coverage by either carrier, subject to the incontestability clause of the contract.

I understand that if I become Medicare eligible while I am covered under the medical contract, any benefits I am entitled to under that contract will be reduced by the amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare.

If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, the insurers shall notify the employer of such differences, and seek the enrollees written consent to issue the different coverage.

All statements and answers in this notice of election are true and complete to the best of my knowledge and belief. Any material misrepresentation may result in Anthem's cancellation of coverage which may result in an otherwise valid claim being denied subject to any applicable incontestability clause.

I certify each Social Security number submitted is correct.

Insurance Fraud Statement: Any person who knowingly and with intent to defraud an 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 material fact there to, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim or each such violation.

Applicant signature X	Print name	Date (MMDDYY)
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Group name		Group no.	Group sub no.	
Street address		City	State	ZIP code
Employee no.	Payroll/Department location		Applicant's full-time employment start date	
Authorized Group Benefits Administrator signature X	Print name		Date (MMDDYY)	