



Anthem Health Insurance Open Enrollment Form

Employee Information:

- Employee Name: _____
 - Address: _____
 - City/State/ZIP: _____
 - Date of Birth: ____ / ____ / _____
 - Social Security Number: ____ - ____ - ____
 - Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
-

Coverage Election

Please select one medical plan option:

- ☐ HSA Plan
- ☐ PPO 1 Plan
- ☐ PPO 2 Plan
- ☐ Waive Coverage

If electing coverage, select your tier:

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family

(PLEASE SEE REVERSE SIDE)

Dependent Information (If Applicable)

Please complete for all dependents to be covered.

First Name	Last Name	Date of Birth	Social Security Number	Relationship to Employee
_____	_____	___/___/_____ _____	__-__-_____ _____	_____
_____	_____	___/___/_____ _____	__-__-_____ _____	_____
_____	_____	___/___/_____ _____	__-__-_____ _____	_____
_____	_____	___/___/_____ _____	__-__-_____ _____	_____

Employee Authorization

I acknowledge that the information provided is accurate to the best of my knowledge. I understand the terms of coverage and authorize any necessary payroll deductions for the plan elected.

Employee Signature: _____

Date: ___ / ___ / _____

For HR Use Only:

- **Effective Date:** ___ / ___ / _____
- **Processed By:** _____