

Important information — To help avoid delays or inaccuracies in the implementation of your plan and the creation of plan materials, it is important that you provide us with complete and current information as requested below.

Section 1: Group Information			
Indicate group name as it should appear on billing statement			
Chamber Name VEGAS CHAMBER	Vegas Chamber Member ID (required)	Affiliated Chamber Name	Affiliated Chamber Member ID
Federal Tax ID	Form of Organization (Corporation, Proprietorship, Partnership, Government Unit/Agency, Corporation or Organization Exempt from Income Tax, Labor Union, etc.)	Is the group subject to ERISA? ☒ Yes ☐ No	
If other than Legal name is to appear on EOCs or separate EOCs for other divisions are needed, list names.		Requested Effective Date	SIC
Section 2: Group contact information			
This individual will interface with Anthem Blue Cross and Blue Shield (Anthem) for major decisions regarding my account:			
Name		Title	
Phone no.	Fax no.	Email address	
Group address:			
Street address		City	State Zip Code
Main phone no.		Billing/Mailing address, if different than physical address	
Section 3: Billing contact			
This individual will interface with Anthem on all billing related issues - if same as above, indicate same:			
Name		Title	
Street Address		City	State Zip Code
Phone no.	Fax no.	Email address	
Section 4: Payment information			
Anthem's preferred method of payment is Demand Debit through an electronic funds transfer (EFT). Please use the attached EFT form in order for Anthem Blue Cross and Blue Shield to set up the initial payment on your behalf. You will be responsible for setting up reoccurring payments through Employer Access.			
Section 5: Terminations			
Terminations will be effective on: ☒ The first of the month following the date of the event (Anthem Standard)			
Section 6: Dependents			
☒ (Anthem standard) The term "child" includes unmarried children of any age medically certified as disabled and children under 26 years old regardless of student status, marital status, financial dependency, eligibility for group sponsored insurance, eligibility as an employee under the same plan, or service in the armed forces. Children can be covered under one, but not both parents when both parents work for the same employer and are covered under the same Anthem plan.			
Section 7: Enrollment information			
Initial identification cards will be mailed to ☒ Employee's residence (as indicated on the Enrollment Census)			
Maintenance identification cards (i.e. new hires) will be mailed to ☒ Employee's residence (as indicated on the Enrollment Census)			
Ongoing enrollment will be loaded into Anthem's system: ☒ EmployerAccess - An easy to access online tool that allows the group/broker to quickly make enrollment additions, changes and terminations.			
Evidence of Coverage (EOC) production and delivery - mark all that apply			
English EOCs are available on anthem.com once members register and log in after they are enrolled. Electronic version of EOC will be sent out to: Group Contact ☐ Other ☐			
Contact name		Email	

Coordination of Benefits			
Standard Coordination of Benefits policy for Anthem in NV is to pay and pursue (meaning Anthem will pay claims if members are eligible and if any possible other coverage situations arise, Anthem will then pursue the possibility of payment by other parties). Please advise your employees of this policy as Anthem may request additional information after a claims has already been processed.			
Section 8: Type of Coverage			
1. Medical Coverage - select plan: ☐ PPO Blue Secure 1 BP (9PSG) ☐ PPO Blue Secure 6 (9PWP) ☐ PPO Choice 1 (9PWC) ☐ PPO Choice 2 (9PWU) ☐ PPO Choice 3 (9LBJ) ☐ PPO Choice 4 (9LC6) ☐ PPO Choice 5 (9LBM) ☐ PPO Choice 6 (9LAY) ☐ PPO Blue Preferred I (9LBE) ☐ PPO Blue SecureLMV1 (9LAF) ☐ PPO Blue SecureLMV1-Lean(9PX0) ☐ PPO Blue Secure 6 BP (9PV4) ☐ PPO Blue Secure 7 (9PVV) ☐ PPO Blue Secure 8 (9PW9) ☐ PPO Blue Secure 8 BP (9PSM) ☐ PPO Blue Secure 10 (9PUY) ☐ PPO Blue Secure 10 BP (9PTY) ☐ PPO Blue Secure 11 (9PVT) ☐ PPO Blue Secure 11 BP (9PS5) ☐ PPO Blue Secure 13 (9PS3) ☐ PPO Blue Secure 13 BP (9PVS) ☐ PPO Blue Secure 13 BP-Lean(9PW1) ☐ H.S.A. 23E 3400 (9LAV) ☐ H.S.A. 24E 5000 (9LAX) ☐ GA HMO 10-0/20% (9PT5) ☐ GA HMO 10-500/20% (9LBG) ☐ GA HMO 10-1000/20% (9PUB) ☐ GA HMO 15-2000/20% (9LB2) ☐ GA HMO 15-4000/30% (9PV2) ☐ GA HMO 15-4000/30% Lean (9PS8) ☐ GA HMO 20-6500/40% (9PWS) ☐ CC HMO H.S.A 1700 (9PWT) ☐ CC HMO H.S.A. 3500 (9PUX) ☐ CC HMO 0-20% (9PUG) ☐ CC HMO 500-20% (9LBD) ☐ CC HMO 1000-20% (9LAC) ☐ CC HMO 2000-20% (9PWX) ☐ CC HMO 3000-20% (9PXA) ☐ CC HMO 4000-30% (9PSJ) ☐ CC HMO 6500-40% (9PUT) ☐ CC HMO 8200-40% (9PW7)			
2. Dental Coverage - select plan: ☐ Essential Choice - Low ☐ Essential Choice - Medium ☐ Essential Choice - High ☐ No dental coverage selected			
3. Vision Coverage - select plan: ☐ FS A.10.20.130.130 (4L28) ☐ FS B. 10.10.130.130 (4M3Q) ☐ FS A. 10.10.150.150 (4P8Z) ☐ FS B. 10.20.150.150 (4Q6H) ☐ FS A. 0.10.180.180 (4R97) ☐ FS B. 10.25.130.130 (4M82) ☐ No vision coverage selected			
Section 9: Contributions			
Choose your medical contribution for each month - only one choice is allowed. Traditional option - (50% to 100%): _____ % per employee _____ % per dependent (optional) Percentage of plan option (50% to 100%): _____ % to _____ plan.			
Choose your dental contribution for each month. _____ % per employee _____ % per dependent (optional) Choose your vision contribution for each month. _____ % per employee _____ % per dependent (optional)			
For Health Savings Account (HSA) plans: Do you want Anthem to facilitate opening a HSA Financial Custodian (bank) account? ☐ Yes ☐ No *Requires completion of questionnaire.			
Section 10: Prior coverage			
Is there other coverage being replaced? ☐ Yes ☐ No If yes, please indicate the carrier and coverage information being replaced.			
Name of prior Medical carrier	Type of coverage being replaced	Start date/end date	Prior carrier's annual deductible (if applicable)
Name of prior Dental carrier	Type of coverage being replaced	Start date/end date	
Section 11: COBRA selection			
Choose COBRA TPA - select one of the two options below: ☐ Health Equity (Included with all plans - General Notice distribution, Qualifying event administration, Election processing, Premium billing and collection) Number of current COBRA participants: _____ Current COBRA Administrator: _____ Number of employees in 60-day election period: _____ Do you offer a Health Flexible Spending Account? ☐ Yes ☐ No ☐ Other COBRA TPA Name: _____			

Section 12: Eligibility and enrollment

1. Average total number of employees during the prior calendar year (including employed owners/officers): _____
2. Number of eligible full-time employees (minimum 30 hours per week): _____
3. Number of employees enrolling in:
Medical: _____ Dental: _____ Vision: _____
4. Number of eligible DECLINING employees: _____
5. Number of INELIGIBLE employees: _____
6. Number of employees working outside of NV: _____
7. Will coverage be restricted to a certain classification of employees? ☐ YES ☐ NO
If yes, please explain what class(es): _____

Probationary period/waiting period for new employees/rehires for Medical/Dental/Vision:

First of the month following: ☐ Date of Hire ☐ 1 month from Date of Hire ☐ 2 months from Date of Hire

Would you like to offer the probationary/waiting period by class? ☐ Yes ☐ No

If yes, please explain classes:

Class 1: _____ Waiting period: _____

Class 2: _____ Waiting period: _____

Would you like to waive the probationary period for ALL existing employees at initial enrollment?

☐ Yes ☐ No

Do you want Domestic Partner coverage?

☐ Yes ☐ No

Section 12: Broker information

Brokerage name	Brokerage Tax ID. no.	Writing Agent name	Writing Agent Tax ID no.
Brokerage street address	City	State	Zip code
Brokerage phone no.	Chamber name	Chamber member ID no.	

Broker Certification - I hereby certify:

- 1 I have reviewed the attached client information questionnaire for completeness and accuracy.
- 2 I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by me initials and date on the application.
- 3 I have not signed any of the applications/questionnaire for an employer representative or individual applicant. If after submission of this application/questionnaire, 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 or HMO Nevada 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 the coverage shall not be effective until Anthem or HMO Nevada reviews and approves the application and the employer receives a written notice from Anthem or HMO Nevada.
- 5 I am the appointed broker and am receiving commissions for the submission of this client. I have disclosed to the applicant all compensation I will or may be eligible to receive as a result of the applicant's business. Absent the written signed consent of Anthem, no portion of my commission payments from Anthem shall be paid to a broker/producer not appointed/approved by Anthem.

Authorized Broker of Record signature X	Printed Name	Date (MM/DD/YYYY)
Writing Agent/Broker Tax ID no.	Broker email address	
Authorized General Agent signature X	Printed Name	Date (MM/DD/YYYY)
General Agent Tax ID no.	General Agent email address	

Section 13: General Agreement

Electronic Access of Group Information by Agent/Producer/Broker/General Agent

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem Blue Cross and Blue Shield or HMO Nevada to access the group's information, such as but not limited to enrollees, plan selection, and bills/invoices. Such agent/producer/general agent is also hereby authorized to use the EmployerAccess system of Anthem Blue Cross and Blue Shield or HMO Nevada to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes.

The agent/producer/broker/general agent must maintain original employee/member enrollment documentation, and shall make them available upon Anthem's request.

☐ Check this box ONLY if the group elects to opt-out of authorizing the agent/producer/broker/general agent to access and change the group's information on behalf of the group.

Terms and Conditions

The undersigned employer and/or authorized representative hereby request(s) approval for insurance coverage by Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada and/or Anthem Life. Our signature below will indicate that Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada and/or Anthem Life are approving coverage. By signing this application, the undersigned employer agrees to be bound by the terms of the contract. The employer agrees that:

1. The employer must maintain records and furnish to Anthem or their designated agent(s), and information required in connection with administration of the coverage. Original source documents, including but limited to employee/member enrollment documentation, shall be made available upon Anthem's request.
2. The requested coverage is not in effect until this application is approved by Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada; 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 application is approved for coverage by Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada. The employer must meet the minimum enrollment, participation and eligibility requirements according to the applicable Anthem underwriting policies and Nevada state law.
3. The advance premium check does not create temporary or interim insurance coverage, and receipt and deposit of that payment does not guarantee issuance of insurance coverage; rather, issuance of insurance coverage is expressly conditioned on Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada determination that the employer satisfies Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on that part of Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada, except to refund the advance premium payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
4. For Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada to accept this application, all the information requested on this application must be completed. If the application is not complete, Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada or their designated agent(s) are authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada may be different from the coverage applied for herein. If Anthem Blue Cross and Blue Shield/Anthem and/or HMO Nevada notifies the employer of such different coverage, and the employer pays the appropriate premium, the employer will be deemed to have accepted the coverage as issued.
5. 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, by contacting Anthem at 1-800-922-4770 or via the EmployerAccess system.

Company officer signature

Title

Printed name

Date (MM/DD/YYYY)