Enrollment Application
Anthem Balanced Funding

Anthem

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary.
Please provide complete details to avoid delay. Please note that no one will be denied health coverage on an individual basis due to the answers provided below.
All information given should apply to this employer.

Section 1: Type of coverage requested

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Plan name selected: _____

If you selected a HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.
If enrolling in a HMO plan, please submit a PCP selection. Anthem's PCP listings can be obtained at anthem.com.

Reason for application

☐ New enrollment ☐ Add ☐ Change
☐ Open enrollment ☐ Cancel
☐ COBRA Event: _____
Date: ____/____/____ (MM/DD/YY)
☐ Waive

Qualifying event– please complete date and reason.
Event date: ____/____/____ (MM/DD/YY)
☐ Marriage ☐ Divorce ☐ Birth of child ☐ Adoption ☐ Terminated employment
☐ Other: _____

Section 2: Group information

Group name			Group no.		Subgroup no.
Group street address	City		State	ZIP code	Full-time hire/rehire date
Employee status ☐ Active ☐ Disabled ☐ Retired ☐ Other: _____	Hours working per week	Occupation	Income reported by ☐ W-2 ☐ 1099 ☐ Other: _____		
If not actively at work, reason					Projected return date

Section 3: Enrollment information

☐ Single ☐ Married ☐ Divorced

Relationship	Last name, First name, M.I.	Social Security no. required*	Sex	Age	Date of birth (MM/DD/YY)	Height	Weight	Current tobacco user	Disabled
Employee			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No

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

Section 3: Enrollment information (continued)

Employee home street address	City	State	ZIP code	County
Employee home phone	Employee work phone	Employee email address		
Dependent home street address – if different from employee	City	State	ZIP code	Dependent names

Section 4: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 10, prior to answering the below questions.

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests (excluding AIDS and HIV) or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name: _____ Due date: ___/___/_____ (MM/DD/YYYY)
4. In the last five years have you or any of your dependents been diagnosed or treated for any of the following? ☐ Yes ☐ No Check all that apply.

- ☐ Arthritis
- ☐ Back/neck disorder
- ☐ Blood/bleeding disorder
- ☐ Cancer/growth/tumor
- ☐ Congenital disease or birth defect
- ☐ Diabetes/thyroid/endocrine disorder
- ☐ Digestive/intestinal disorder
- ☐ Heart/circulatory disorder
  - ☐ Aneurysm
  - ☐ High blood pressure
  - ☐ Coronary artery disease/heart attack
- ☐ Immune disorder (other than HIV)
  - ☐ Lupus
- ☐ Infertility/reproductive organ disorder
- ☐ Kidney/bladder/urinary disorder
- ☐ Liver/pancreas disorder
- ☐ Mental/nervous disorder
  - ☐ Depression
  - ☐ Alcohol or substance abuse
- ☐ Muscular dystrophy
- ☐ Nervous system disorder
  - ☐ Cerebral palsy
  - ☐ Migraines/cluster headaches
  - ☐ Multiple sclerosis
  - ☐ Parkinson's
  - ☐ Seizures/epilepsy
  - ☐ Stroke
- ☐ Respiratory/lung disorder
  - ☐ Asthma
  - ☐ Bronchitis/COPD
  - ☐ Emphysema

☐ Other condition: _____

Explain "Yes" answers to any question in section 3. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date (MM/DD/YY)	Date(s) of treatment	Hospitalized	Surgery	Recovered
							☐Y ☐N	☐Y ☐N	☐Y ☐N
							☐Y ☐N	☐Y ☐N	☐Y ☐N
							☐Y ☐N	☐Y ☐N	☐Y ☐N
							☐Y ☐N	☐Y ☐N	☐Y ☐N

Section 5: Waiver of coverage — Must be completed if employee and/or dependents waive medical coverage.
NOTE: If waiving coverage, please complete this section. Section 8 must also be signed and dated.

Medical coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s)

Reason for declining coverage – Check all that apply:

☐ Covered by spouse's group coverage ..... Carrier name: _____ ID no.: _____
☐ Enrolled in other insurance provided by my employer Carrier name: _____ ID no.: _____
☐ Enrolled in individual coverage ..... Carrier name: _____ ID no.: _____
☐ Spouse covered by employer's group medical coverage
☐ Medicare
☐ Other: _____
☐ No coverage

Section 6: Other health insurance information

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No				
Family members covered by other health coverage				
Insurance company name			Policy no.	Effective date (MM/DD/YYYY)
Insurance company street address	City	State / ZIP code		Insurance company phone no.
Policy/certificate holder's name	Social Security no.	Date of birth (MM/DD/YYYY)		Relationship to applicant
Family members covered by Medicare				Medicare ID no.
Part A effective date	Part B effective date	Medicare eligibility reason – Check all that apply ☐ Age ☐ Disability ☐ ESRD – Onset date: (MM/DD/YYYY)		
Medicare Part D carrier	Medicare Part D ID no.	Part D effective date	Part D termination date	

Section 7: Over-age Dependent Affidavit

By initialing below, I verify and attest that my dependent(s), age 26 and over, is/are unmarried and financially or otherwise dependent on me due to mental and/or physical disability; and therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year as specified by the certificate. I understand that Anthem reserves the right to request, at any time, proof of over-age dependency.

Initials: _____

Section 8: Significant Terms, Conditions and Authorizations (TERMS) please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross and Blue Shield (Anthem) with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

1. I may not assign any payment under my Anthem program unless required by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied.
3. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage).

In addition, if I have a dependent as a result of marriage, birth,adoption or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. For a period of two (2) years from the earlier of the policy date or the issue date, Anthem may deny benefits, rescind your policy or cancel coverage based on material misrepresentation or significant omission found in this application.

I certify each Social Security number listed on this application is correct.

For myself and any dependents, I'm signing here because, I agree to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my benefits, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by signing, information about my dependents may also be sent by email or electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependents) will update our communication preferences by going to anthem.com or calling Member Services.

By signing below, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem.

Applicant signature	Printed name	Date (MM/DD/YYYY)
X		

Thank you for choosing Anthem Blue Cross and Blue Shield.