

# Employee Change Form For Small Groups Nevada



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](http://anthem.com). Please complete electronically or in black ink only and use extra paper if necessary.

Section A: General Information			
Employer name			Group no.
Employee last name	Employee first name	M.I.	Employee Social Security no. <sup>1</sup> (required) - -
Section B: Employee Information — Required			
<b>Reason for change — Required. Select all that apply.</b>			
<input type="checkbox"/> Address change	<input type="checkbox"/> Add Spouse/Domestic Partner or dependent	<input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel product(s)	
<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel Spouse/Domestic Partner or dependent	<input type="checkbox"/> Enrollment in Medicare (Fill in Section E)	
<input type="checkbox"/> Benefit change	<input type="checkbox"/> Change Primary Care Physician (PCP)	<input type="checkbox"/> Other: _____	
<b>Event reason — Required. Select all that apply.</b>			
<input type="checkbox"/> Open enrollment	<input type="checkbox"/> Loss of coverage	<input type="checkbox"/> Other insurance	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child
<input type="checkbox"/> Death		<input type="checkbox"/> Termination	<input type="checkbox"/> Court ordered coverage
<input type="checkbox"/> Other — please explain: _____			
<b>Event date/Requested effective date — Required</b> ____/____/____ (MM/DD/YYYY)			
Home address — Street or P.O. Box if applicable		City	State ZIP Code
County	Birthdate (MM/DD/YYYY) / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner
Primary phone no.		Occupation	
Email address: _____			
<p>I'm providing my email address because <b>I, and my enrolled dependents, want to receive information about our benefits electronically.</b> These communications may include Identification (ID) Cards, Certificates of Coverage, billing invoices, Explanation of Benefits, Evidence of Insurability underwriting documents, 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 <a href="http://anthem.com">anthem.com</a> 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, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to <a href="http://anthem.com">anthem.com</a> or calling the Member Services number on my ID card.</p>			

<sup>1</sup> Anthem is required by the Internal Revenue Service to collect this information.

**Section C: Family Information** — Dependents (includes Spouse or Domestic Partner and child(ren)) to be added/changed/cancelled. Attach a separate sheet if necessary.

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<b>Event reason — Required. Select all that apply.</b> <input type="checkbox"/> Open enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Other — please explain: _____			
	<b>Event date/Requested effective date — Required</b> ____/____/____ (MM/DD/YYYY)			
Dependent Last name		First name	M.I.	Social Security no. <sup>1</sup> (required) - - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other <sup>2</sup> If other, what is the relationship? _____	
PCP name		PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PCD name		PCD ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the Dependent(s) have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____				

**Section D: Plan/Type of Coverage****1. Medical Coverage**

Medical product plan name:	Contract code, if known:
<b>Member medical coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	

**2. Dental Coverage**

Dental product plan name:	Contract code, if known:
<b>Member dental coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	

**3. Vision Coverage**

Vision product plan name:	Contract code, if known:
<b>Member vision coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	

**Section E: Prior and Other Group Coverage** — Attach a separate sheet if necessary.

Is anyone applying for coverage currently eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, give name: _____			
Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason (select all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-stage renal disease: Onset date (MM/D/YYYY) ____/____/____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes   ☐ No   If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			<b>Start:</b> ____/____/____ <b>End:</b> ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			<b>Start:</b> ____/____/____ <b>End:</b> ____/____/____

<sup>1</sup> Anthem is required by the Internal Revenue Service to collect this information.<sup>2</sup> Eligibility subject to Booklet or Certificate of Coverage.

**Section F: Terms and Conditions** — Please read this section carefully before signing the application.**Eligible employee:**

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

**Eligible dependent** (see Booklet or Certificate of Coverage for complete dependent eligibility terms):

- Employee's Spouse/Domestic Partner or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for a child will end on the last day of the month in which the child reaches age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of a mental or physical impairment that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of such mental or physical impairment and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

**Section G: Authorizations** — Please read this section carefully and then sign below.**In signing this application I represent that:**

- I have read, or have had read to me, the completed application. All statements and answers I have given are true and complete, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I am an eligible employee and I am requesting coverage for myself and all eligible dependents listed on this application.
- I certify each Social Security number listed on this application is correct.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I understand that I may not assign any payment under my Anthem program.
- I authorize my employer to deduct any required contributions for this insurance from my wages.
- I am asking for the coverage I chose on this application. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
- I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage, and that no right is created by my application for coverage.
- I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
- I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and that I may provide Anthem with a written request to revoke my authorization at any time.
- By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and me.

I understand 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 denial of insurance benefits. I also understand all benefits are subject to conditions stated in the Group Contract and the Booklet or Certificate of Coverage.

I give this authorization for myself and on behalf of my eligible dependents, including my Spouse/Domestic Partner, if covered by Anthem, and I am acting as their agent and representative. If my Spouse/Domestic Partner signs this application, he/she is giving this authorization on his/her own behalf.

<b>Sign here</b>	<b>Applicant signature</b> (or custodial parent's or guardian's signature if applicant is under 18)	<b>Today's date (MM/DD/YYYY)</b>
	X	/ /
	<b>Spouse/Domestic Partner signature</b>	<b>Today's date (MM/DD/YYYY)</b>
	X	/ /

# We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

## Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

## Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的ID卡片上的會員服務電話號碼。若您視障人士，還可索取本文件的其他格式版本。

## Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

## Korean

귀하는 자국어로 무료 지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

## Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

## Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

## Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

## Farsi

"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

## French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

## Arabic

لك الحق في الحصول على مساعدة بلغتك مجاناً. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

## Japanese

お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

## Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

## Italian

Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

## Polish

Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

## Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

## TTY/TTD:711

## It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>