Anthem

PPO Enrollment Application

Welcome to Anthem Blue Cross and Blue Shield (Anthem). This is your *Enrollment Application and Change Form*. Because we are dedicated to making the enrollment process easy for you, this form may be used to enroll in medical coverage, as well as dental, vision, and life and disability insurance coverage where available. This form may also be used to waive coverage, change information, cancel coverage or re-enroll. When completing this form, please follow the guidelines listed below. Anthem appreciates the opportunity to serve you.

- **Complete all required information and print legibly in all capital letters.** Inaccurate or illegible information will be returned, causing a delay in the application process.
- If you or another member of your family applying for coverage under this policy had health insurance within the last six months before enrolling with Anthem, **you must complete section 4** in order to receive credit for this coverage against pre-existing condition time periods. You have the right to obtain a Certificate of Creditable Coverage from your prior plan. Please contact Customer Service at the number listed on your health benefit ID card for assistance in obtaining such certificate or if you have questions regarding pre-existing conditions.
- If you are applying for BluePriority coverage or Dental HMO, you must indicate the primary care physician (PCP) and/or primary care dentist (PCD) choice for each enrollee on the first page of this application. If you do not indicate a PCP/PCD, we may need to select one for you. You can find a PCP/PCD online at anthem.com by clicking **Find a Doctor**.
- Be sure to read the entire application, including the information on the back pages.
- If you have a dependent with a mental or physical disability, as certified by your dependent's physician, that physician must complete a *Mentally/Physically Disabled Dependent Enrollment Request Form.*
- Please contact your group benefits administration if you have any questions about the forms mentioned above, or if you need help in completing this application.
- You may also visit anthem.com to obtain certain forms. After you log in, select **Customer Support**, then select **I need to Download Forms**.

To enroll/open enrollment

- When enrolling for coverage for the first time, please complete sections 1, 2, 3 and 4 completely and sections 5 and 7, if applicable.
- After reading all areas of the application, read section 8, and sign and date the *Enrollment Application* where requested.

To waive coverage

- To waive coverage for yourself, complete sections 2, 3 and 6.
- Read section 8, and sign and date the *Enrollment Application* where requested.

To change information

- If you need to make a change for yourself or one of your eligible dependents, please complete section 1. Be sure to include the date the change becomes effective.
- In section 3, please list all family members affected by the change. If you are changing your address, you may fill in your new address in this section. If you are adding a dependent, he/she must be added within 31 days of becoming eligible (60 days, if eligibility is due to involuntary loss of coverage under a state child health insurance program or a state Medicaid plan), as defined by your plan.
- Indicate any other changes in the applicable areas of sections 2, 4, 5 or 7.
- Read section 8, and sign and date the *Enrollment Application* where requested.

After completing this form

- Read through the instructions above and make any required corrections. This will help ensure that your application is processed as quickly and accurately as possible.
- Promptly deliver your completed *Enrollment Application* to your group benefits administrator.

Enrollment Application and Change Form
Medical, Dental, Vision, Life and Disability

Anthem

Check all coverage that applies: ☒ Medical ☐ Dental ☐ Vision ☐ Life ☐ Disability ☐ FSA

Social Security no.[1] (Required) _____ (must be completed by **employee**)

Member no. _____ (must be completed by **employee**)

Employer case no. _____ (must be completed by **employer**)

~~Dental group /subgroup no. _____ (must be completed by employer)~~

~~Life group no. _____ (must be completed by employer)~~

Section 1: Reason for completing application

☐ New enrollment ☐ Beneficiary change ☐ Reinstatement of coverage ☐ Personal information change ☐ Coverage change
☐ Canceling coverage ☐ Other: _____
Qualifying event (See section 8 for requirements on qualifying events/special enrollments.): _____
Change effective date: _____ (MM/DD/YY)

Section 2: Benefits and coverage desired

Ask your employer for the medical, dental and vision coverage options available. For life and disability insurance coverage option, see page 4. Ask your employer if coverage for domestic partner (DP)[2] is offered.

Medical benefit plan:
☐ PPO: PPO $1000 BlueSecure $25/1000/80%
☐ PPO with HRA: _____
☐ HIA Plus: _____
☐ HRA: _____
☐ HSA[3]: HSA $3000/100%
☐ Other: _____

Medical coverage: ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)

~~**Dental coverage plan:** ☐ Dental Prime (select one) ☐ Option 1 ☐ Option 2~~
☐ Dental Complete (select one) ☐ Option 1 ☐ Option 2
☐ Essential Choice: _____
☐ Consumer Choice: _____
☐ Other: _____

~~**Dental coverage:** ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)~~

~~**Vision coverage plan:** ☐ Blue View Vision~~
☐ Other: _____

~~**Vision coverage:** ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)~~

~~**FSA coverage plans:** ☐ Healthcare Flexible Spending Account ☐ Limited Purpose Flexible Spending Account ☐ Dependent Care Flexible Spending Account~~
☐ Commuter Transit ☐ Commuter Parking

~~**FSA coverage:** ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)~~

1 Anthem is required by the Internal Revenue Service to collect this information.
2 A person named as Domestic Partner (DP) under a Certificate of Registered Domestic Partnership where required by Nevada law.
3 Confirm with your employer which HSA custodian was selected.

Required: Employee Social Security/member no.: _____

Section 3: Employee and family information

List yourself and all eligible family members who are applying for or waiving coverage. Include domestic partner information only if coverage for domestic partner is offered by your employer. Use a separate sheet, if needed.

☐ Add ☐ Change ☐ Cancel ☐ Waive

Employee last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship **Self**
Mailing street address for member correspondence	City		State	ZIP code	Home phone no.
Email address	Hire date	Employment date	☐ Hourly ☐ Salaried	Hours worked/ week	Earnings: $_____ Per: _____
Full company name HUMBOLDT COUNTY			Position title		
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel ☐ Waive

Spouse/Domestic partner last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship (required) ☐ Spouse ☐ Domestic partner
Social Security no.[1] (Required)	If you and your spouse/domestic partner have different last names, check the applicable box: ☐ Spouse/DP retaining name				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel ☐ Waive

Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship
Social Security no.[1] (Required)	☐ Over-age Mentally/Physically Disabled Dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered Health Care Coverage (Attach copy of court order.)				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel ☐ Waive

Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship
Social Security no.[1] (Required)	☐ Over-age Mentally/Physically Disabled Dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered Health Care Coverage (Attach copy of court order.)				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

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

Required: Employee Social Security/member no.:

Section 3: Employee and family information (continued)

☐ Add ☐ Change ☐ Cancel ☐ Waive

Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship

Social Security no.[1] (Required)	☐ Over-age Mentally/Physically Disabled Dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered Health Care Coverage (Attach copy of court order.)

Primary Care Physician (PCP)	PCP ID no.	Current patient ☐ Yes ☐ No

Primary Care Dentist (PCD)	PCD ID no.	Current patient ☐ Yes ☐ No

Section 4: Prior and other insurance

Have you or any of your dependents had any other coverage in the last 12 months or currently have coverage other than the applied-for coverage?
☐ Yes ☐ No If yes, please complete the section below for all covered members. If coverage remains in force, do not complete the end date section of the form below. Use a separate sheet for additional entries, if needed.

Member name (first, middle initial, last)	**Type**	**Carrier** (name, phone no., and policy ID)	**(MM/DD/YY)**
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:

Section 5: Medicare coverage — Complete if you, your spouse/domestic partner or dependent child(ren) have Medicare coverage. Use a separate sheet if needed.

Member name (first, middle initial, last)	Part A effective date (MM/DD/YY)	Part B effective date (MM/DD/YY)	Reason for disability if under age 65	Medicare claim no.

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

Required: Employee Social Security/member no.: _____

Section 6: Waiver of insurance — Complete only if you intend to waive insurance.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application.

The plan has been explained to me, and I decline to participate.

☐ **I do not want to participate in the group insurance plan at this time for the following reason(s):** (Check all that apply.)

- ☐ I have other group health insurance.
- ☐ I have other group dental insurance.
- ☐ I have other group vision insurance.
- ☐ I have other individual health insurance.
- ☐ I have no other insurance coverage, and I am not interested at this time.
- ☐ I have religious objections (non-contributory life insurance).
- ☐ I am a dependent of an active or retired military service member.
- ☐ I am retired from military service.
- ☐ I do not wish to participate (contributory life insurance).
- ☐ I and/or my dependent(s) have coverage under a state child health insurance program or a state Medicaid plan.

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: Signature required

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back page, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem and me.

I understand that by signing the field below labeled "Employee signature" I agree to get information about my benefits by email or electronically for myself and my dependents. 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 or 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.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry.

Description of Special Enrollments

If you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility under the state child health insurance program or state Medicaid plan. However, you must request enrollment within 60 days: (1) after the date the coverage under a state child health insurance program or a state Medicaid plan ends; or (2) after the date you become eligible for state premium assistance for group coverage.

In addition, if you have a new dependent as a result of marriage/registered domestic partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage/registered domestic partnership, birth, adoption or placement for adoption.

To request special enrollment submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-877-811-3106; or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

Employee signature	Date (MM/DD/YY)
X	

Important legal information

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry.

- I hereby authorize my employer, until this authorization is revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.
- If applying for health insurance coverage, I certify that I work at least 30 hours per week for the employer named in the application.
- I certify each Social Security Number listed on this application is correct.
- If I decline health coverage for myself and/or my dependent(s) (including my spouse/domestic partner) because of other group or individual health insurance coverage except coverage under a state child health insurance program or a state Medicaid plan, I may in the future be able to enroll myself and/or my dependent(s) in this plan, provided that I request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage/registered domestic partnership, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage/registered domestic partnership, birth, adoption or placement for adoption.
- If I decline health coverage for myself or my dependents (including my spouse/domestic partner) because of coverage under a state child health insurance program or a state Medicaid plan, I may in the future be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility under the state child health insurance program or state Medicaid plan, provided that I request enrollment within 60 days: (1) after the date the coverage under a state child health insurance program or a state Medicaid plan ends; or (2) after the date I become eligible for state premium assistance for group coverage. I also understand that if I do not enroll myself and/or my dependents within 60 days, I may enroll at a later date and may be subject to the pre-existing condition below.
- If you decline health coverage for a PPO, you understand that you will not be able to enroll until the next open enrollment period, or within 31 days after a qualifying event (see above), as defined by the plan and may be subject to the pre-existing exclusion below.

I understand that I may be required to submit additional information upon request.

Notice of pre-existing condition exclusion (Pre-existing condition exclusion does not apply to policies that have been issued or renewed on or after January 1, 2014.)

Depending upon the terms of your plan and when it is offered, your plan may impose a pre-existing period. The pre-existing condition exclusion does not apply to pregnancy; dependent children who are enrolled in the plan within 31 days after birth, adoption, or placement for adoption; or persons under 19 years old. Pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins.

This exclusion may last up to six months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can receive credit toward this exclusion period if you have had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to waive the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To have the six-month exclusion period waived based on your prior creditable coverage, you should give us a copy of any Certificates of Creditable Coverage you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Anthem at 1-877-811-3106, or mailed to Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver CO, 80217-5858.