

Employee Enrollment Application For 2-50 Employee Small Groups Virginia



And Its Affiliate HealthKeepers, Inc.

Health care plans offered by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. PPO health care plans are insurance products offered by Anthem Blue Cross and Blue Shield; HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. Life and Disability plans offered by Anthem Life Insurance Company.

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.

To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Application completed for (check company that applies)

- Anthem Blue Cross and Blue Shield
- HealthKeepers, Inc.
- Anthem Life Insurance Company

Please complete in blue or black ink only.

Section A: Employee Information				
Last name	First name	M.I.	Social Security no.	
Home address – Street and PO Box if applicable		City	State	ZIP code
City/County	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married	Primary phone no.	Secondary phone no.	
Employee email address				
Employer name			Group no. (if known)	
Employer street address		City	State	ZIP code
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	Hire date (MM/DD/YYYY)	First date of full-time employment (MM/DD/YYYY)	No. of hours worked per week	
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other – please specify: _____				
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, the translator must sign and submit a Statement of Accountability				
Section B: Application Type				
Select one				
<input type="checkbox"/> New enrollment	<input type="checkbox"/> COBRA – Select qualifying event <input type="checkbox"/> Left employment <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Medicare			Qualifying event date _____
	<input type="checkbox"/> Reduction in hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Covered employee's Medicare entitlement		<input type="checkbox"/> Death	

Life and Disability products underwritten by **Anthem Life Insurance Company, Anthem Health Plans of Virginia, Inc.** trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO **HealthKeepers, Inc.** are independent licensees of the Blue Cross Blue Shield Association.

© ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section C: Type of Coverage

1. Medical Coverage

Enter network, product and contract code selected:

Network – select one: <input type="checkbox"/> KeyCare <input type="checkbox"/> HealthKeepers <input type="checkbox"/> HealthKeepers Open Access	Product	Contract code
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Note for Lumenos Health Savings Account (HSA) enrollees:
If you enroll in an Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one: Employee only Employee + Spouse Employee + child(ren) Family

Please Note:
You must enroll in the pediatric dental coverage option/rider/endorsement unless you will be enrolled in a standalone dental plan that has been certified by a state Exchange. To determine if your standalone dental plan has been certified by a state Exchange, please refer to your health plan enrollment information or the website for your state Exchange. If you will be enrolled in a standalone dental plan meeting this requirement, please check here.

2. Dental Coverage

I am enrolling in my Employer’s dental plan.

Member dental coverage – select one: Employee only Employee + Spouse Employee + child(ren) Family

3. Vision Coverage

I am enrolling in my Employer’s vision plan, if any.

Member vision coverage – select one: Employee only Employee + Spouse Employee + child(ren) Family

4. Life and Disability Coverage

If you select Life and/or Disability coverage over the guarantee issue amount or are a late entrant an Evidence of Insurability form will be sent to you to complete.

<input type="checkbox"/> Basic Life & AD&D	<input type="checkbox"/> Short-Term Disability	<input type="checkbox"/> Optional Life & AD&D	Life Class
<input type="checkbox"/> Basic Dependent Life	<input type="checkbox"/> Long-Term Disability	<input type="checkbox"/> Optional Dependent Life & AD&D	
Current income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			Occupation

Primary Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB’s information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.)
 If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature X	Spouse name	Date
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Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents to be covered under this coverage. An eligible dependent may be your spouse, your children, or your spouse's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Employee last name	First name	M.I.	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 Self		PCP name			PCP ID no.
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Spouse last name	First name	M.I.	Social Security no.	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 Spouse		PCP name			PCP ID no.	
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Dependent last name	First name	M.I.	Social Security no.	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"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		PCP name			PCP ID no.	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____						
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Dependent last name	First name	M.I.	Social Security no.	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"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		PCP name			PCP ID no.	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____						
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Dependent last name	First name	M.I.	Social Security no.	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"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		PCP name			PCP ID no.	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____						
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Section F: Waiver/Declining Coverage

Medical Coverage

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
- Enrolled in other Insurance –
Please provide company name and plan: _____
- Enrolled in Individual coverage
- Spouse covered by employer's group medical Coverage
- Medicare/Medicaid/TriCare
- Other – please explain: _____
- No coverage

Dental Coverage

Dental coverage declined for – check all that apply: Myself Spouse Dependent(s)

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes.

Vision Coverage

Vision coverage declined for – check all that apply: Myself Spouse Dependent(s)

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further vision enrollment changes.

Life Coverage

Life coverage declined for: Myself

I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here *only* if you are declining coverage.

Signature of applicant X	Printed name	Social Security no.	Date (MM/DD/YYYY)
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Section G: Terms, Conditions and Authorizations

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 31 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:

- Employee's spouse or children younger than age 26, 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. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of intellectual disability or physical handicap 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 handicap 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.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

For Health Savings Account enrollees: 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 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.

Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

Sign here	Applicant signature	Date (MM/DD/YYYY)
	X	

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you 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 your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

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



And Its Affiliate HealthKeepers, Inc.