

Member Enrollment/Member Change Form

TO BE COMPLETED BY EMPLOYER		
Firm division no.	Health benefit plan	Requested effective date

SECTION 1. EMPLOYEE INFORMATION

Current Anthem contract no., if any	Last name	First name	M.I.
Home street address or PO box		City	State ZIP code
Home phone no.	Work phone no.	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Legally separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Email address			

SECTION 2. ENROLLMENT REASON

New group (initial enrollment) Annual enrollment New hire

COBRA/CGS 38A-538: Reason: _____ Qualifying event date: ___/___/___

SECTION 3. CHANGE STATUS — Please check the reason(s) for change below and indicate date

Type of change

Name (indicate former name) _____ Address Other reason: _____ Date: ___/___/___

SECTION 4. MEMBERSHIP CHOICES

	Individual	Two person	Family
<input type="checkbox"/> Access Blue New England	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blue Care Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blue Choice New England	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Century Preferred/PP0 Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HMO Blue New England	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos HSA* Plan Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos HRA Plan Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos HIA Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos HIA Plus Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blue View Vision Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Plan name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Confirm with your employer which HSA custodian was selected.

Are you or any other eligible dependent listed on this form currently confined to a hospital or other health care facility, totally disabled or physically impaired?
 Yes No

SECTION 5. EMPLOYER INFORMATION

Company name

Are you actively at work? Yes No
If no, reason: Sick Injured Other _____

Are you currently claiming Workers' Compensation medical benefits?
 Yes No

Date of full-time hire** | Date of part-time hire** | Date of rehire** (if applicable) | Do you work 30 or more hours per week?
 Yes No Hours: _____

**Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

SECTION 6. EMPLOYEE AND DEPENDENT INFORMATION – List only family members you wish to add or cancel

Add	Cancel	Vision	Name(s) of person(s) (Last name, first name, M.I.)	Sex	Birthdate (MM/DD/YYYY)	Full-time student age 19 or over?	Name of recognized institution for full-time students	Primary Care Physician (PCP) name (Refer to provider directory or anthem.com) Put an X the box <input type="checkbox"/> if you currently use this physician
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self	<input type="checkbox"/> M <input type="checkbox"/> F				Name City <input type="checkbox"/> PCP no.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SSN					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Legal spouse <input type="checkbox"/> Domestic partner	<input type="checkbox"/> M <input type="checkbox"/> F				Name City <input type="checkbox"/> PCP no.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SSN					

Children up to age 26 may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dependent	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		Name City <input type="checkbox"/> PCP no.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SSN					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dependent	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		Name City <input type="checkbox"/> PCP no.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SSN					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dependent	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		Name City <input type="checkbox"/> PCP no.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SSN					

SECTION 7. PRIOR COVERAGE INFORMATION – This section must be completed

Do you or any other member of your family have any other medical, dental, or Anthem Blue Cross and Blue Shield coverage?

Yes No If yes, please complete the following.

	Self	Spouse/Domestic Partner	Dependents		
			1	2	3
Name of insurance company					
Certificate (policy) no.					
First and last date of coverage					
Reason for termination					

SECTION 8. MEDICARE/MEDICAID INFORMATION

Do you or any covered member have Medicare/Medicaid coverage?

Yes No

Have you or any covered member applied for Medicare/Medicaid disability?

Yes No

Name(s) of Medicare beneficiaries	Are you actively at work?	Retirement date (MM/DD/YYYY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					

SECTION 9. EMPLOYEE SIGNATURE – Required

For insurance entities, the term "medical loss ratio" refers to the ratio of incurred claims to earned premium for a prior calendar year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2012, Anthem's Medical Loss Ratio for state law purposes was 82.8% for HMO plans and 83.7% for PPO/Indemnity plans. For 2012, Anthem's MLR for federal law purposes was 85.7% for small group plans and 90% for large group plans.

I understand that intentionally false and/or intentionally incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

Employee signature X	Print name	Date
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