Employee Enrollment Application
For 51–99 employee groups
Virginia

Anthem And Its Affiliate HealthKeepers, Inc.

Anthem Life

PPO health care plans, including dental and vision coverage, are insurance products offered by Anthem Blue Cross and Blue Shield (Anthem); HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. (HealthKeepers); Life and disability plans are insurance products offered by Anthem Life Insurance Company (Anthem Life).

Instructions:

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.
Please complete electronically or in blue or black ink only.

Application completed for (check company that applies)

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

Employer name	Group no.	Subsection

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner – If available through your employer.	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

☐ New enrollment
☐ Annual open enrollment (not applicable to life and disability)
☐ New hire
☐ Rehire – Rehire date: _____ (MM/DD/YYYY)
☐ Marriage – Date of marriage: _____ (MM/DD/YYYY)
☐ Birth of child
☐ Add dependent (Fill in section 4)
☐ Loss of eligibility for other coverage – Date previous coverage ended: _____ (MM/DD/YYYY)
☐ COBRA – Select qualifying event
- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Medicare
- ☐ Loss of dependent child status
- ☐ Divorce or legal separation
- ☐ Covered employee's Medicare entitlement

Qualifying event date: _____ (MM/DD/YYYY)

☐ Waiver (To decline ALL coverage skip to section 7.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage — Check company(ies) and write in product that applies. Application completed for:

☐ Anthem Blue Cross and Blue Shield — Product name: _____

☐ HealthKeepers, Inc. — Product name: _____ Point of service (POS)

Member medical coverage — select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + one child ☐ Employee + children ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage — More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Complete Essential Choice
☐ Other: _____

Member dental coverage — select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + one child ☐ Employee + children ☐ Family ☐ No coverage

Vision coverage

☐ Materials Only Buy Up ☐ Other: _____

Member vision coverage — select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + one child ☐ Employee + children ☐ Family ☐ No coverage

Life and disability coverage

If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse . . . . . $_____ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child . . . . . $_____ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income For employer use For Anthem use $_____	Occupation	Life and disability class no. For employer use For Anthem use

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Social Security no.* (required)

Primary beneficiary

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

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

Contingent beneficiary – If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

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

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	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.

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 medical 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 1-866-692-6901.

If an applicant's age at the time of application is at least 15 but less than 18, and the applicant lives with a parent, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.

Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse's 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/Domestic Partner signature **X**	Spouse/Domestic Partner name	Date

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Social Security no.* (required)

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. If available through your employer, an eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner'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.

Spouse or Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No **If yes, please enter:** ______			

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No **If yes, please enter:** ______			

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No **If yes, please enter:** ______			

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Social Security no.* (required)

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ 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 (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: ____ (MM/DD/YY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

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Social Security no.* (required)

Section 6: Terms, Conditions and Authorizations (TERMS)

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/HealthKeepers/Anthem Life 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 Anthem/Healthkeepers /Anthem Life; 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:

- For Anthem Blue Cross and Blue Shield and Healthkeepers only, eligible dependents are employee's spouse, domestic partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild, domestic partner's child, foster child, 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.
- For Anthem Life Insurance Company only, eligible dependents are employee's spouse, domestic partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or domestic partner's child. 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. ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

In signing this application I represent 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.

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

I agree to receive emails with supplemental information, such as newsletters, to help me get the most out of my plan. I agree to provide Anthem/HealthKeepers/Anthem Life with my most up to date email address. I know I can opt out or change my mind at any time by contacting Anthem/HealthKeepers/Anthem Life.

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/HealthKeepers with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem/HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem/HealthKeepers with a written request to revoke my authorization at any time.

Life and/or Disability enrollees: Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.

These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Employee signature

X

Date (MM/DD/YYYY)

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Social Security no.* (required)

Section 7: Waiver/Declining coverage

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner'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/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental coverage

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

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner'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/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Vision coverage

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

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner'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/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life, Accidental Death & Dismemberment (AD&D) and Disability coverage

***Life/AD&D** coverage declined for: ☐ Myself
Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life coverage
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that 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	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

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