Member Enrollment/Member Change Form

Anthem BlueCross BlueShield

To be completed by employer		
Firm division no.	Health benefit plan	Requested effective date (MM/DD/YYYY)

Section 1. Employee information

Current Anthem contract no., if any	Last name	First name	M.I.

Home street address or P.O. box	City	State	ZIP code

Home phone no.	Work phone no.	Marital status:
		☐ Single ☐ Married ☐ Legally separated ☐ Separated ☐ Widowed ☐ 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
☐ Access Blue New England	☐	☐	☐
☐ Blue Care Plan name: _____	☐	☐	☐
☐ Blue Choice New England	☐	☐	☐
☐ Century Preferred/PPO Plan name: _____	☐	☐	☐
☐ Century Preferred/EPO Plan name: _____	☐	☐	☐
☐ HMO Blue New England	☐	☐	☐
☐ HSA[1] Plan Plan name: _____	☐	☐	☐
☐ HRA Plan Plan name: _____	☐	☐	☐
☐ HIA Plan	☐	☐	☐
☐ Dental Plan name: _____	☐	☐	☐
☐ Blue View Vision Plan name: _____	☐	☐	☐
☐ Other Plan name: _____	☐	☐	☐

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[2]	Date of part-time hire[2]	Date of rehire[2] (if applicable)	Do you work 30 or more hours per week? ☐ Yes ☐ No Hours: _____

1 Confirm with your employer which HSA custodian was selected.
2 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	Date of birth (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 on anthem.com)	Current Patient?
☐	☐	☐	Self Social Security no.[1] (required)	☐ M ☐ F				Name City PCP no.	☐ Yes ☐ No
☐	☐	☐	☐ Legal spouse ☐ Domestic partner Social Security no.[1] (required)	☐ M ☐ F				Name City PCP no.	☐ Yes ☐ No
Children up to age 26 or disabled dependents may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.									
☐	☐	☐	Dependent Social Security no.[1] (required)	☐ M ☐ F		☐ Yes ☐ No		Name City PCP no.	☐ Yes ☐ No
☐	☐	☐	Dependent Social Security no.[1] (required)	☐ M ☐ F		☐ Yes ☐ No		Name City PCP no.	☐ Yes ☐ No
☐	☐	☐	Dependent Social Security no.[1] (required)	☐ M ☐ F		☐ Yes ☐ No		Name City PCP no.	☐ Yes ☐ No

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 (Anthem) 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
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ 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 2015, Anthem's Medical Loss Ratio for state law purposes was 81.4% for HMO plans and 81.4% for PPO/Indemnity plans. For 2015, Anthem's MLR for federal law purposes was 84.6% for small group plans and 89.9% 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.

I'm signing here because I want to get information about my benefits by email or electronically. 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 plan, 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 know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

W-9 Certification Language: I certify each Social Security number listed on this application is correct.

Employee signature	Print name	Date (MM/DD/YYYY)
X		

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

Instructions (Please print all information.)

Thank you for choosing our plan.
Please read these instructions before filling out the attached *Member Enrollment/Member Change Form*. Here's what you need to fill out, so we can enroll you without delay.

For new enrollment, complete all sections.

For membership changes, complete:

Section 1. Employee information

Section 3. Change status

In addition, when adding/canceling eligible dependents, or changing a Primary Care Physician (PCP), complete:

Section 6. Employee and dependent information

Section 7. Prior coverage information

Section 8. Medicare/Medicaid information

Section 1. Employee information

Please complete all information in this section.

Section 2. Enrollment reason

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a-538 extension of coverage member, please indicate the date of the qualifying event, and also the reason code.

Reason code	Qualifying event	Reason code	Qualifying event
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

Section 3. Change status

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:
Address Adoption Birth Dependent Divorced Legally Separated Married Name PCP

Section 4. Membership choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice(s). If you choose "BlueCare", "Dental", "Blue View Vision", or "other", please be sure to write the name of the plan as instructed by your Benefits Coordinator.

B. Please check individual, two person or family for each plan choice.

Section 5. Employer information

Please complete all information in this section.

Section 6. Employee and dependent information

A. Please be sure to complete all information in this section including Social Security numbers, and the name(s) of recognized institution(s) for full-time student dependent(s) age 19 or over if required by your employer's guidelines for eligibility.

B. Indicate last name if different.

C. If any dependent(s) listed are disabled, please circle that dependent, and attach the appropriate application which may be obtained from your Benefits Coordinator.

D. Special instructions for BlueCare. A Primary Care Physician (PCP) must be selected for each member. Each member may choose a different PCP. Specialists cannot be selected as PCPs. Please also write in the city or town where the PCP's office is located, and the PCP provider number, located in the Provider Directory on anthem.com.

An asterisk (*) next to a physician's name in the provider listing means the physician can only be seen by a current patient. If you are a current patient and want that physician to be your PCP, please check the "Yes" box under the Current Patient column next to the PCP.

E. If coverage is available through your employer's plan for domestic partnerships, please include the appropriate certification forms.

Section 7. Prior coverage information

Please be sure to note any other insurance information in this section.

Section 8. Medicare/Medicaid information

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare or Medicaid disability.

Section 9. Employee signature

Application will not be considered valid if unsigned. Please sign and return the completed application to your employer's Benefits Coordinator. Save your copy of this form for your records until you receive your identification card(s). A copy of this application is provided to you as part of your *Subscriber Agreement* or health benefit plan document as applicable and is incorporated by reference therein.

Definitions

The definitions listed below are for informational purposes only. For additional information, please refer to your Master Group Policy, *Subscriber Agreement*, or the *Evidence of Coverage*.

Eligible employee: An Eligible Employee is defined as a full-time employee of the employer. In order to qualify as a full-time employee, the employee must be actively at work and working at least 30 hours per week on a regularly scheduled basis unless a higher number of hours per week is required by the employer. Part-time employees must work at least 20 hours per week. (Part-time coverage may not be offered by all employers.) Temporary employees and seasonal employees are not eligible for coverage.

Eligible dependents:

a. An Eligible Employee's spouse under a legally valid existing marriage.

b. For insured accounts: A child[1] of an Eligible Employee up to age 26 if the child meets Anthem's guidelines for dependent eligibility under federal and state law. Please check with Anthem regarding those guidelines.

c. For self-insured accounts: A child[1] up to age 26 who meets your employer's guidelines for eligibility. Please check with your employer regarding those guidelines.

Exception for newborn: Newborn children are automatically entitled to coverage for the first 61 days following birth. If no additional premium is due Anthem, a completed Enrollment and Membership Change Form must be submitted to Anthem within a reasonable amount of time following birth in order to continue coverage without interruption. *If additional premium is required, a completed Enrollment and Membership Change Form must be submitted to Anthem within 61 days following birth in order for coverage to be continued without interruption.*

Late enrollee: An Eligible Employee and/or dependent who requests insurance more than 31 days after the employee's earliest opportunity to enroll for coverage under any plan sponsored by the Employer may be considered a late enrollee. Late Enrollees who are eligible for coverage will not be denied coverage, and completion of a statement of health form may be required. An Eligible Employee and/or dependent will not be considered a Late Enrollee, if a request for coverage is made and all of the following conditions satisfied: (1) Coverage was not elected when the employee was first eligible under the group policy solely because another group health insurance plan provided coverage for the employee; and (2) Coverage is lost under that plan due to employment termination, death of a spouse, divorce, legal separation, loss of eligibility, COBRA benefit is exhausted, reduction in the number of work hours for employment, or the employer stops contributing to the health benefit plan; and (3) The employee applies for coverage under this contract within 31 days after loss of coverage under the other plan.

Actively at work: The term Actively at Work means the employee must: work at the employer group's place of business or at such place(s) as normal business requires; and perform all the duties of the job as required of a full-time employee working the minimum number of hours per week on a regularly scheduled basis.

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.

Waiting period: Means a period of time that must pass before an employee or a dependent is eligible to enroll in the plan. The Anthem standard waiting period allows for new hires to be eligible to enroll for coverage following 30 days of continuous "actively at work employment." Generally new hires and their dependents who apply for coverage more than 31 days from the date first eligible will be considered a Late Enrollee.

Effective dates: New hires and their dependents will be effective the first of the month following completion of the waiting period. Waiting period cannot be greater than a total of 90 days. Effective dates for new hires may be deferred if all required information is not received, or is incomplete.

Affiliation period: Means a period of time that must expire before health coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits. No premium shall be collected for such period.

Open enrollment period: The term open enrollment means the period of time during which an employer group allows employees to select group health coverage.

1 "Child" includes a natural child, a legally adopted child or a child legally placed for adoption, a step-child, a child supported by the employee pursuant to a valid court order, or a child for whom the employee is legal guardian.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-738-6644). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-738-6644). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-738-6644). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-738-6644). (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-738-6644)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-738-6644. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-738-6644). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-738-6644). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-738-6644) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-738-6644). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-738-6644)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-738-6644). (TTY/TDD: 711)

Portuguese-Europe
Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (855-738-6644). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-738-6644). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-738-6644). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-738-6644). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.