Member Enrollment/Member Change Form

Anthem BlueCross BlueShield

TO BE COMPLETED BY EMPLOYER		
Firm division no. Firm division no.	Health benefit plan Health benefit plan	Requested effective date (MM/DD/YYYY) 01/01/0001

SECTION 1. EMPLOYEE INFORMATION

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

Home street address or PO box	City	State	ZIP code
123 Main St. Apt. 1	Anytown	NY	12345

Home phone no.	Work phone no.	Marital status
123-456-7890	123-456-7890 1234	☑ Single ☐ Married ☐ Legally separated ☐ Separated ☐ Widowed ☐ Divorced

Email address: personal@email.com

SECTION 2. ENROLLMENT REASON

☑ New group (initial enrollment) ☐ Annual enrollment ☐ New hire
☐ COBRA/CGS 38A-538: Reason: Reason Qualifying event date: 01/01/0001

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

Type of change
☑ Name (indicate former name): If name change, ☑ Address ☑ Other reason: Please indicate Date: 01/01/0001

SECTION 4. MEMBERSHIP CHOICES

		Individual	Two person	Family
☑ Access Blue New England		☑	☐	☐
☐ Blue Care	Plan name: Blue Care: Plan Name	☑	☐	☐
☐ Blue Choice New England		☑	☐	☐
☐ Century Preferred/PPO	Plan name: Century Preferred/PPO: Plan	☑	☐	☐
☐ Dental	Plan name: Dental: Plan Name	☑	☐	☐
☐ HMO Blue New England		☑	☐	☐
☐ Lumenos HSA* Plan	Plan name: Lumenos HSA* Plan: Plan Name	☑	☐	☐
☐ Lumenos HRA Plan	Plan name: Lumenos HRA Plan: Plan Name	☑	☐	☐
☐ Lumenos HIA Plan		☑	☐	☐
☐ Lumenos HIA Plus Plan		☑	☐	☐
☐ Blue View Vision	Plan name: Blue View Vision: Plan Name	☑	☐	☐
☐ Other	Plan name: Other: Plan Name	☑	☐	☐

*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: Company Name

Are you actively at work? ☑ Yes ☐ No
If no, reason: ☑ Sick ☐ Injured ☐ Other: Please describe

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?
01/01/0001	01/01/0001	01/01/0001	☑ Yes ☐ No Hours: 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	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 Doe John Quincy SSN *(required) 123-45-6789	☑ M ☐ F	01/01/0001			Name 1. Primary Care City 1. City PCP no. 1. PCP no.	☐ Yes ☑ No
☑	☑	☑	☑ Legal spouse ☐ Domestic partner 2. Name of person SSN *(required) 2. SSN (required)	☑ M ☐ F	01/01/0001			Name 2. Primary Care City 2. City PCP no. 2. PCP no.	☑ Yes ☐ No
Children up to age 26 may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.									
☑	☑	☑	Dependent 3. Name of person SSN *(required) 3. SSN (required)	☑ M ☐ F	01/01/0001	☑ Yes ☐ No	3. Name of recogniz ed	Name 3. Primary Care City 3. City PCP no. 3. Primary	☑ Yes ☐ No
☑	☐	☐	Dependent 4. Name of person SSN *(required) 4. SSN (required)	☑ M ☐ F	01/01/0001	☑ Yes ☐ No	4. Name of recogniz ed	Name 4. Primary Care City 4. City PCP no. 4. PCP no.	☑ Yes ☐ No
☑	☐	☐	Dependent 5. Name of person SSN *(required) 5. SSN (required)	☑ M ☐ F	01/01/0001	☑ Yes ☐ No	5. Name of recogniz ed	Name 5. Primary Care City 5. City PCP no. 5. PCP no.	☑ Yes ☐ No

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

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	Name of	Name of	1. Name	2. Name	3. Name
Certificate (policy) no.	Certificate	Certificate	1.	2.	3.
First and last date of coverage	First and last	First and last	1. First	2. First	3. First
Reason for termination	Reason for	Reason for	1. Reason	2. Reason	3. Reason

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
1. Name of Medicare beneficiaries	☑ Yes ☐ No	01/01/	1.	01/01/	01/01/	01/01/
2. Name of Medicare beneficiaries	☑ Yes ☐ No	01/01/	2.	01/01/	01/01/	01/01/
3. Name of Medicare beneficiaries	☑ Yes ☐ No	01/01/	3.	01/01/	01/01/	01/01/

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.

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

Employee signature	Print name	Date (MM/DD/YYYY)
X *John Doe*	John Doe	01/01/0001

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* 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* 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 Blue Cross and Blue Shield, a completed Enrollment and Membership Change Form must be submitted to Anthem *Blue Cross and Blue Shield* 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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.

* "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.