Employer Application for Administrative Services Kentucky

Anthem Anthem Life

Please complete electronically, or in blue or black ink only. For more information about Anthem, its products and services, visit anthem.com.
Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respects to claims.

Group no.

Section 1: Company information

☐ New enrollment ☐ Renewal/Plan amendment	Benefit year ☐ Calendar year ☐ Plan Year	Requested effective date (MM/DD/YYYY)

Applicant (legal name of group)	Tax ID/FEIN (required)
Name of association (if applicable)	
Company street address	

City	County	State	ZIP code
Billing address – If different from above			
City	County	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Company (LLC) ☐ Labor union ☐ Trust
☐ Government unit/agency ☐ Other: _____

SIC code – Required	Type of business	No. of years in business

Group administrator name	Primary phone no.
Email address	Fax no.
Additional company contact name	
Email address	Primary phone no.

Current group carrier	Current carrier effective date	Type of coverage	Type of funding

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No
Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No

Union name (attach copy of agreement)	Union no.	Contract expiration date

Group no.

Section 1: Company information — Continued

List all affiliates/subsidiaries/divisions (list names, locations, no. employed at each location.) Attach a separate page to show any separate billing addresses, and any separate billings for life classes.

Names of affiliates/subsidiaries/divisions	Location	No. of employees per location

Total no. of employees residing/working outside of home office state	List no. of employees at each office location

Has your group been turned down for coverage in the last 12 months? ☐ Yes ☐ No
If yes, by whom, when, and why? _____

Will any insurance carrier(s), in addition to Anthem, provide medical coverage as part of the group's employee benefit plan? ☐ Yes ☐ No
If yes, list carrier(s) and product(s) offered: _____

In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal/state bankruptcy laws (Chapter 11 or 7) or state receivership? ☐ Yes ☐ No

In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy? ☐ Yes ☐ No

Section 2: Type of coverage

Medical coverage

Large Group 51–99 options

☐ Pathway EPO
☐ Blue Access (PPO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO HRA (with Copay)

Large Group 100+ options

☐ Anthem Essential (PPO)
☐ Blue Access (PPO)
☐ Blue Preferred (HMO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO Deductible First HRA
☐ Blue Access PPO HRA
☐ Blue Access PPO HRA (with Copay)
☐ Pathway EPO

For CDHP accounts (HSA/HRA) plans:

Do you want Anthem to facilitate opening a Health Savings Account Financial Custodian (bank) account? ☐ Yes ☐ No
If yes, requires completion of questionnaire.

Flexible Spending Account (FSA) coverage — Multiple plans can be selected.

☐ 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 Quote ID: _____
☐ Other: _____ Quote ID: _____
☐ Complete Essential Choice Quote ID: _____

Vision coverage

☐ Vision

Contribution requirements

Choose your group contribution level for each month:

Medical: _____% per employee _____% per dependent (optional)
Dental: _____% per employee _____% per dependent (optional)
Vision: _____% per employee _____% per dependent (optional)

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No
If yes, explain: _____

Group no.

Life and disability coverage — Please check all that apply and attach your quote/proposal with the application. A minimum of two employees must enroll.

Life/AD&D products	Disability products
Choose life product and group contribution percentage:	**Choose disability product and group contribution percentage:**
☐ None	☐ None
☐ Basic Life _____%	☐ Short Term Disability _____%
☐ Basic Life & AD&D _____%	☐ Long Term Disability _____%
☐ Basic Dependent Life _____%	☐ Voluntary Short Term Disability _____%
☐ Supplemental/Voluntary Life and AD&D _____%	☐ Voluntary Long Term Disability _____%
☐ Supplemental/Voluntary Dependent Life _____%	

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre- or post-tax basis. If it varies by class, attach additional page with class-level information.

Short Term Disability: ☐ Pre tax ☐ Post tax Voluntary Short Term Disability: ☐ Pre tax ☐ Post tax

Long Term Disability: ☐ Pre tax ☐ Post tax Voluntary Long Term Disability: ☐ Pre tax ☐ Post tax

Life and/or disability probationary period/waiting period

Would you like to waive the probationary period/eligibility waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in life and/or disability plans after the group's coverage effective date the same as the Anthem medical policy eligibility period? ☐ Yes ☐ No

If no, enter the life and disability eligibility probationary period below. Attach additional page if more than three classes.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

Prior coverage

Do you have any existing life insurance or disability insurance with this or any other company? ☐ Yes ☐ No

Do you intend with the purchase of this insurance to replace, terminate or change the value of any existing life insurance or disability insurance with this or any other company? ☐ Yes ☐ No

If yes, provide information below for each policy or contract being replaced and attach any applicable replacement forms:

Will this plan replace current?	Insurance company name	Policy/contract no.	Termination date (MM/DD/YYYY)
Life/AD&D coverage ☐ Yes ☐ No			
Disability coverage ☐ Yes ☐ No			

Life band rate changes and Life reductions in coverage due to age:

☐ First of month following date of birth
☐ Group anniversary

Short Term Disability plans and benefits elected above do not replace state-mandated disability benefits. If you want Anthem Life to be your state-mandated disability/paid family leave carrier an additional application and proposal are required. Contact your broker for more information.

Group no.

Continuity of Coverage - Life Insurance

The employees listed below are not presently actively at work and/or are not expected to be actively at work on the requested group effective date. Anthem Life may consider life coverage for these employees on a no loss/no gain basis if all of the following conditions are satisfied: 1) The employee's absence must be due to illness or injury or leave of absence. 2) The employee must be covered by the prior carrier on the day immediately prior to Anthem Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. 4) With respect to Disability coverage, the employee must not be absent from work due to a disability: a) that began prior to Anthem Life's effective date of coverage for your group; b) for which benefits are payable or being paid under the prior plan in the absence of this provision.

In no event will any increase in life coverage or any additional life coverage become effective until the employee returns to work. Coverage approved below will end in accordance with the Policy provisions. (Attach additional sheet if necessary.)

Employee name	Amount of insurance	Date of birth	Last date worked	Reason not working (e.g., injured, sick, FMLA, or approved leave)	Date expected to return	Insured by prior carrier	Date applied for life waiver of premium with prior carrier	Date applied for life conversion with prior carrier
						☐ Yes ☐ No		
						☐ Yes ☐ No		
						☐ Yes ☐ No		

Group Accident, Critical Illness, and Hospital Indemnity Insurance

Refer to sold case proposal for plan details.

☐ Accident Insurance – Contract code 1:_____ Contract code 2:_____ Contract code 3:_____

☐ Critical Illness Insurance – Contract code 1:_____ Contract code 2:_____ Contract code 3:_____

☐ Tobacco rated ☐ Uni-Tobacco

☐ Hospital Indemnity Insurance – Contract code 1:_____ Contract code 2:_____ Contract code 3:_____

Medicare Part D coverage

Prescription drug benefits: ☐ Wrap ☐ Waiver ☐ Subsidy

If subsidy (CMS Information needed): Plan sponsor ID:_____ Application ID:_____

Unique benefit option identifier:_____

Group no.

Section 3: Eligibility

Eligible full-time employees must work at least 30 hours per week, must be actively at work and must have satisfied any applicable eligibility waiting period.
Eligible full-time employees do not include temporary or seasonal employees.

Total number of employees (including part-time): _____

Total number of full-time employees (including those within their waiting period): _____

Total number of full-time employees in employee waiting period: _____

Probationary period/waiting period for eligible enrollees:
☐ None ☐ First of month after hire date ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days

Do any classes of employees have a different waiting period? ☐ Yes ☐ No If yes, explain:

New eligible enrollees will become effective on:
☐ Day following completion of waiting period/probationary periods **(required for selection of 90 day waiting period)**
☐ First of month following completion of waiting period/probationary period

Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No Note: Domestic partner coverage is not available for life and disability plans.

Is your group subject to COBRA? ☐ Yes ☐ No
Do you have a COBRA administrator? ☐ Yes ☐ No
Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No If yes, please complete and sign the COBRA agreement.

List employees/dependents on Continuation of Coverage/COBRA	Name of persons in COBRA eligibility period	List all totally disabled employees and dependents

ERISA qualified? ☐ Yes ☐ No

Employee termination effective date: ☐ End of month ☐ End of day

Section 4: Open enrollment — Does not apply to Life and Disability coverage.

Our standard open enrollment period is at least 31 days prior to the group's renewal date and 31 days following, which is held no less frequently than once in any 12 consecutive months. If you want to designate a different open enrollment period, please indicate the following:

Start date: ⌊ ⌋ End date: ⌊ ⌋ (MM/DD/YYYY)

Group no.

Section 5: Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that Anthem Blue Cross and Blue Shield (hereinafter "Anthem" unless otherwise specified) administer certain health care benefits of employer's self-insured group health plan pursuant to the terms of the administrative services agreement. Employer, through an authorized representative, understands and agrees by payment of the required fees, to the following:

1. To comply with all terms and provisions of the administrative services agreement issued, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the healthcare benefits available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the health care benefits.
4. To provide notice of applicable conversion rights and rights to continue health care benefits under COBRA to eligible employees and eligible dependents.
5. That acceptance of this application may cancel any prior contract(s) or administrative services agreement with Anthem effective immediately preceding the effective date of the administration of health care benefits.
6. To pay Anthem by the due date stated in the administrative services agreement, the fees on behalf of each member enrolled for health care benefits, unless otherwise stated in the administrative services agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and/or conversion process, if applicable.
7. That claims filed by or on behalf of members may, at Anthem's option, be suspended if fees are not timely received.
8. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
9. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application.
10. The fees calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such fees upon receipt of all individual applications for employers' employees and to modify the fees, if the enrollment information so warrants.
11. The entire application for third-party administrative services has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
12. All employees applying for benefits are employees of the employer and receive salary or wages documented on state and/or federal payroll reports.
13. The agreement is not in effect unless and until this application is accepted by Anthem, that agreement shall be evidenced by issuing an administrative services agreement to the employer, and an employee's health care benefits are not in effect unless and until the employee enrolls.
14. The employer acknowledges that he has signed the attached benefit proposals indicating the benefits requested.
15. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
16. STD benefits for employees eligible for state disability plans in CA, HI, NJ, NY, PR or RI will be integrated with the state mandated program in that state. The volume calculated for monthly premium will be based on the total benefit amount, and not reduced by the state mandated benefit.
17. The employer understands that when health care services are obtained outside the geographic area Anthem serves, claims for those services may be processed through the BlueCard program, as defined in the administrative services agreement. Employer understands and agrees (1) to pay certain fees and compensation to Anthem which Anthem's obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to the BlueCard vendors, unless Anthem's contract obligations to employer requires those fees and compensation to be paid only by Anthem and (2) that fees and compensation under BlueCard may be revised from time to time without employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.

Fraud notice

Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Section 6: Signature — Please attach a check for the first month's fees, including stop loss premium, if applicable. Read section 5 carefully before signing.

Printed name of authorized group representative	Title	
Signature of authorized group representative X		Date (MM/DD/YYYY)
Accepted by Anthem's Underwriting Department – Signature X	Title	Date (MM/DD/YYYY)

Employee Enrollment Application
Association Health Plan Coverage
Kentucky

Anthem Blue Cross and Blue Shield | AnthemLife

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.

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	Height	Weight	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner			

Employee email address

Employment status	Current tobacco user?	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired	☐ Yes ☐ No		

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 9.)

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

Reset Form | Save and Print

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Association Health Plan Coverage options

☐ Anthem Essential (PPO)
☐ Blue Access (PPO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO HRA (with Copay)

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ 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/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ 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/Anthem use	Occupation	Life and disability class no.– For employer/Anthem use
$_____		

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

Social Security no.* (required)

Life and disability coverage — Continued

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.

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 signature **X**	Spouse name	Date (MM/DD/YYYY)

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

Social Security no.* (required)

Voluntary Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Voluntary Accident Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ **Voluntary Critical Illness Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: _____

☐ **Voluntary Hospital Indemnity Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO , when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? ☐ Yes ☐ No (Please note that if the response is No, such applicants are not eligible for coverage)

Voluntary Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

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.

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

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. 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.
Note: Domestic partner coverage is not available for life and disability plans.

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No
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	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No
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	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No
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	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No
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:** ______			

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

Social Security no.* (required)

Section 5: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 7, prior to answering the below questions.

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary (with the exception of AIDS/HIV)? ☐ Yes ☐ No
3. Are you, or any of your dependents, currently pregnant? ☐ Yes ☐ No
   If yes, name: _____ Due date: (MM/DD/YY)
4. In the last five years, have you or any of your dependents, been diagnosed with AIDS or HIV? ☐ Yes ☐ No
5. In the last five years, have you or any of your dependents, been diagnosed or treated for any of the following? ☐ Yes ☐ No
   If yes, check all that apply.

- ☐ Arthritis
- ☐ Back/neck disorder
- ☐ Blood/bleeding disorder
- ☐ Cancer/growth/tumor
- ☐ Congenital disease or birth defect
- ☐ Diabetes/thyroid/ endocrine disorder
- ☐ Digestive/ intestinal disorder
- ☐ Heart/circulatory disorder
  - ☐ Aneurysm
  - ☐ High blood pressure
  - ☐ Coronary artery disease/ heart attack
- ☐ Immune disorder (other than HIV)
  - ☐ Lupus
- ☐ Infertility/reproductive organ disorder
- ☐ Kidney/bladder/ urinary disorder
- ☐ Liver/pancreas disorder
- ☐ Mental/nervous disorder
  - ☐ Depression
  - ☐ Alcohol or substance abuse
- ☐ Muscular dystrophy
- ☐ Nervous system disorder
  - ☐ Cerebral palsy
  - ☐ Multiple sclerosis
  - ☐ Seizures/epilepsy
  - ☐ Migraines/cluster headaches
  - ☐ Parkinson's
  - ☐ Stroke
- ☐ Respiratory/lung disorder
  - ☐ Asthma
  - ☐ Bronchitis/COPD
  - ☐ Emphysema
- ☐ Transplants
- ☐ Other condition: _____

Explain "Yes" answers to any question in section 5. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date (MM/DD/YY)	Date(s) of treatment (MM/DD/YY)	Hospitalized	Surgery	Recovered
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

Social Security no.* (required)

Section 6: 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:

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

Social Security no.* (required)

Section 7: Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Anthem program unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. I represent that my answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my approval date may cause a material change in coverage or premium rates. Any materially false statement or misrepresentation found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

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

By signing this application, I understand that I will 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. After I enroll, I can change my communication preferences by calling Member Services or going to anthem.com. I can also call Member Services to request a free copy of specific materials by mail.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 8: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 7 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MM/DD/YYYY)
X	

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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

Social Security no.* (required)

Section 9: 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 and disability coverage

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

Dependent Life coverage declined for: ☐ Spouse and dependents

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse 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 Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223
Anthem Life Insurance Company: P.O. Box 105448, Atlanta, GA 30348-5448

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