NEW BUSINESS CHECKLIST
Group Requirements: 2 – 50 Employees

Anthem

Group Name	Effective Date
Group's address	City, State and Zip Code
Broker Name	Broker Number
Group's e-mail	Return Quote to

To insure prompt processing, the following items must be submitted:

- ☐ Quote from Broker Portal (final rates may need to be signed off)
- ☐ Employer Application
- ☐ Employee Application (applications are valid for **120 days** from the signed date. If there are Cobra applicants, we will need the Cobra event, event date and the end date of each employee requesting Cobra)
- ☐ Waivers for employees not electing coverage **(Valid waiver – Individual on or off exchange)**
- ☐ First month's premium
- ☐ Group eligibility documents
- ☐ Most recent Quarterly Wage report and / **payroll no longer needed for new hires**
- ☐ **Participation – 50% of net eligible**
- ☐ Most Recent prior carrier bill, only if Cobra participants (Prior carrier bill needs to be dated within 60 days of the requested effective date.)
- ☐ CDHP plans may need additional forms, such as Agreement for HSA Agreement and / or Bank Authorization form.

Email request to:

kweyer@iiak.org

Mail to:

Independent Insurance Agents of KY
13265 O'Bannon Station Way
Louisville, KY 40223

Rev. 09/05/13

Tax Documents for New Groups Without a Wage and Tax*

Anthem

Purpose – to tie all employees/owners to the enrolling group and determine full-time status whenever possible.* ***UW requires the UI3 (State Quarterly Wage and Tax).* *The documents below would be used only when the group isn't required by law to file that form or hasn't been in business long enough to file. Hopefully, this guide will assist you with tax forms that may be available when the UI3 isn't.*

BUSINESS TYPE	IN BUSINESS MORE THAN 3 MONTHS	IN BUSINESS LESS THAN 3 MONTHS
"C" Corps	UI3 (State Quarterly Wage & Tax) **OR** State Quarterly Unemployment Report	Payroll Records **AND** Articles of Incorporation **OR** Form SS-4 (Tax ID app)
"S" Corps	UI3 (State Quarterly Wage & Tax) **OR** State Quarterly Unemployment Report Schedule K1 for Shareholders Income	Payroll Records **AND** Articles of Incorporation **OR** Form SS-4 (Tax ID app)
PARTNERSHIPS	**FOR EMPLOYEES WHO ARE PARTNERS**	**FOR EMPLOYEES WHO ARE PARTNERS**
(General partners will not have Form 941 or W2. Income information is found on Schedule K1 – line 15A.)	Schedule K1 – Partner's Share of Income **OR** Schedule SE – (Self-employment Tax) **OR** Form 1065 – Partnership Return of Income **AND** **For any employees who aren't partners** UI3 (State Quarterly Wage & Tax) OR State Quarterly Unemployment Report	Partnership Agreement **AND** Form SS-4 (Tax ID app) **AND** **For employees who aren't partners** Payroll Records
Limited Liability Company (LLC)	May file as a "C" Corp or a Partnership. Determine which one and see requirements above.	May file as a "C" Corp or a Partnership. Determine which one and see requirements above.
SOLE PROPRIETORSHIP	**FOR EMPLOYEES WHO ARE SOLE PROPRIETORS**	**FOR EMPLOYEES WHO ARE SOLE PROPRIETORS**
(Sole Proprietor will not appear on Form 941; however, other employees should appear.)	Schedule SE (Self-employment Tax) **AND** Schedule C (Profit and Loss) which are filed with Form 1040 (Income Tax Return) **AND** **For employees who aren't sole proprietors** UI3 (State Quarterly Wage and Tax) **OR** State Quarterly Unemployment Report	Payroll Records **AND** Form SS-4* (Tax ID app) **Note: A sole proprietor may use their Social Security no. instead of applying for a Tax ID no.* **For employees who aren't sole proprietors** Payroll Records
INDEPENDENT CONTRACTORS		
Independent Contractors	Form 1099 (Only working owners and partners are eligible.)	
FARMS		
	Form 1040 (Income Tax Return) **AND** the schedule the group files (F, K1, etc.) Depending on the group, farms may also file Form 1041, 1065 or 1065B.	Payroll records **AND** Form SS-4 or Articles of Inc. or Partnership Agreement, whichever applies.
NON-PROFIT ORGANIZATIONS		
	There are many forms that may be filed under non-profit status. The best way to determine which form is used is to ask the group what form they actually file with the government. Churches/religious organizations may have K-2/W-2 forms even when non-profit.	

Remember that employers also file a quarterly federal tax return (Form 941) if all else fails.

IRS web site for forms: www.irs.gov/pub/irs-pdf/f1120.pdf
(The f1120 means Form 1120 so you would enter whichever form number you're looking for.)

(10/02)

Employer Application

Group size 2-50 eligible employees

Please complete in ink and use extra sheets of paper if necessary
For more information about Anthem, its products and services, visit **www.anthem.com.**

Anthem Health Plans of Kentucky, Inc.

Anthem Life Insurance Co.

Anthem use:

Group/Account #	Approved SIC	Anthem's Approved Effective Date / /	State ☐ Kentucky	Tracking ID

1. Effective date

Requested effective date: / /

2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

- ☐ Blue Access® (PPO)
- ☐ Anthem Essential℠ PPO
- ☐ Blue Preferred® (HMO)
- ☐ Anthem ByDesign® (ABD) Buy-up/Health Savings Account (HSA)
- ☐ Blue Traditional® (Indemnity)
- ☐ Lumenos® Health Savings Account
- ☐ Lumenos® Health Reimbursement Account
- ☐ Lumenos® Health Incentive Account
- ☐ Lumenos® Health Incentive Account Plus
- ☐ Dental Blue® 100
- ☐ Dental Blue® 100/200/300
- ☐ Vision
- ☐ Basic Life
- ☐ Basic AD&D
- ☐ Dependent Life
- ☐ Optional Life
  - ☐ EE Only
  - ☐ SPS Only
  - ☐ CHD Only
  - ☐ SP/CHD
- ☐ Optional AD&D
- ☐ Short Term Disability
- ☐ Long Term Disability

3. Employer Information

Applicant (legal name of group)		Name of association (if applicable)		
Name and title of head of firm		Name and title of administrative contact		
Home office address	City	County	State	ZIP Code
eMail address		Phone number *(include area code)*	Fax number *(include area code)*	
Billing address and/or contact *(if different from above)*		Tax ID/FEIN (Required)	Number of years in business	

Type of business

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No	Total # of employees residing/working outside of Home Office state

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID no. and number of employees employed by each. ☐ Yes ☐ No

Name of current health and/or life carrier(s)	Next Renewal Date / /

Do you want Anthem to facilitate opening a Health Savings Account with Mellon? ☐ Yes ☐ No		Is your group Section 125? ☐ Yes ☐ No
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 employee/dependents on Continuation of Coverage/COBRA	Names of persons in COBRA eligibility period	

4. Medicare Secondary Payer

☐ Does **not** employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute *(The group agrees to notify Anthem Blue Cross and Blue Shield as soon as this statement is no longer true.)* ☐ Does employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute

5. Eligibility

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

Number of full time employees (including those within their waiting period)	Total number of employees (including part-time)	Total number of employees not Actively At Work	Employees currently in their waiting period will have coverage effective: ☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on:
The day after ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days of employment *or the* ***first billing date*** *after* ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days of employment

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

6. Contribution and Minimum Participation Requirements *Employer must have at least two employees enrolled in health to maintain coverage under this plan.*

Group contribution level for health: 50% of the single fee premium; at least 25% of total premium. For life, AD&D, STD, LTD: at least 25% of premium for each coverage except dependent life. If group contribution is 100%, 100% participation is required. Group minimum participation for Health: at least 75% of "Net Eligible Employees". "Net Eligible Employees" is the total number of eligible employees less those employees with other group health coverage through a spouse or as part of a collectively bargained or union plan.

Group contribution level for insurance
Health _____% Basic Life _____% Basic AD&D _____% Dependent Life _____% Optional Life _____% Optional AD&D _____% STD _____% LTD _____%
(Dental/Vision contributions should match the medical; however, when it does not, it must be at least 25 percent of the total, but not less than 50 percent of the single rate.)

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

7. Signature ***PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read the back of this form carefully before signing)***

Signature and title of authorized group representative	Print name of authorized group representative	City/state where signed	Date / /
Accepted by Anthem's Underwriting Department — Signature and title			Date / /

Group Name: _____

8. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's and Anthem Life's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the coverage 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 coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statement of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem, by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial 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 state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. 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.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
11. 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. The employer understands that the coverage issued by Anthem may be different that the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates 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 rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage 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.
14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work 30 or more hours per week (unless otherwise approved by Anthem in writing), and meet any other eligibility requirements for coverage; employer meets the definition of small employer under applicable law of the state where it is domiciled, which is: An employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. 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.

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.

9. Broker Certification - I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I am not aware of any health history of any applicant that does not appear on the application.
3. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
4. I have not signed any of the applications for a group representative or individual applicant.
5. I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker name		Broker Signature	
Address			Broker ID number
Tax ID number to be paid	Broker phone number	Broker e-Mail address	Broker fax number
Agency name *(if applicable)*		General agency broker	
Address	Date / /	Anthem sales representative	

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

Underwriting Questionnaire
For Groups 51-99

Anthem Health. Join In.℠

HEALTH | DENTAL | VISION | LIFE | DISABILITY

Anthem Blue Cross and Blue Shield would like to thank you for giving us the opportunity to quote your business. We recognize that choosing a health care benefits provider is an important decision and we appreciate your trust and confidence in our service.

Anthem Blue Cross and Blue Shield can offer your employees the full spectrum of benefits all from one source. Our Specialty Product portfolio of Dental, Vision, Life and Disability products feature competitive rates, administration ease and the possibility of added discounts on your health insurance premiums through our One Solution Savings Program.

SECTION 1: PLEASE COMPLETE ALL QUESTIONS

Prospect name	Contact person		
Street address (please include suite no.)			
City	State	ZIP code	County
Nature of business	SIC code	No. of eligible employees	No. of covered employees

Please list all locations and number of employees at each location.

Location	No. of employees
1.	
2.	
3.	

SECTION 2: EMPLOYER CONTRIBUTION

Employee pays %	Employee+spouse pays %	Employee+Child(ren) pays %	Family pays %	Any COBRA? ☐ Yes ☐ No	No. covered by COBRA

If less than five years, please list previous carriers up to five years.

Previous carriers	From	To
1.		
2.		
3.		

Current carrier and benefits. Describe.

SECTION 3: PLEASE PROVIDE THE CURRENT AND RENEWAL SPECIALTY RATES, PLAN DESIGN, CENSUS AND INSURANCE CERTIFICATE

CURRENT RATES	Health	Dental	Vision	Life	Effective date	Carrier
Employee						
Employee + spouse						
Employee + child(ren)						
Family						
RENEWAL RATES	**Health**	**Dental**	**Vision**	**Life**	**Effective date**	**Carrier**
Employee						
Employee + spouse						
Employee + child(ren)						
Family						

Current disability rates	Current carrier

SECTION 3: PLEASE PROVIDE THE CURRENT AND RENEWAL ANCILLARY RATES, PLAN DESIGN, CENSUS AND INSURANCE CERTIFICATE *(CONTINUED)*

Please indicate claims over $10,000 or any known health conditions in the past year for any employee/dependent, active and disabled.
Please give nature of claim

Note: Please remember to have certificates, and a census with salary and occupation when submitting your application.

Broker name/agency	Producer name	Producer no.
Anthem representative signature **X**	Agent no.	Date
Employer signature **X**		Date

FOR OFFICIAL USE ONLY

Underwriting approval/disapproval ☐ Approved ☐ Disapproved	Date

Medicare Secondary Payer

Anthem

Employer Status Form

Please complete this form to assist with compliance with the Medicare Secondary Payer regulations of the Centers for Medicare and Medicaid Services (CMS). You may want to check with your legal counsel to confirm the Medicare Secondary Payer requirements.

Group name	Group contact
Group identification no.	Telephone no.

The business or organization ("Group") named above:

☐ Does **NOT** ☐ Does

have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year, **and**

☐ Does **NOT** ☐ Does

have 100 or more employees on 50 percent or more of its regular business days during the preceding calendar year.

"Employees" include (even if they are not eligible for Anthem group health plan benefits):

- Part-time, full-time and leased employees;
- Persons not working but receiving payments normally subject to FICA taxes, such as persons on disability for the first six months.

If the Group is part of a controlled group of employers under IRC Sec. 52(a) and (b) or an affiliated service under IRC Sec. 414(m), then all employees in the aggregated group of employers must be included in the count of the Group's employees.

The Group agrees to notify Anthem Blue Cross and Blue Shield as soon as the statement above is no longer true.

The Group employed _____ (number) of such "employees" as of _____ (date).

If this form states a change in the category (i.e., under 20, over 20 or over 100 employees) for the Group, then a copy of the business' or organization's latest wage and tax statement must be attached and returned with this form.

I certify that the information provided above is true to the best of my knowledge and belief.

Group administrator signature	Date

Rev. 1/07

Enrollment Application

Group size 2-50 eligible employees

Anthem Health Plans of Kentucky, Inc.

Anthem Life Insurance Co.

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. *All information given should apply to this employer.*

1. TYPE OF COVERAGE REQUESTED: ☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family ☐ Life Only ☐ No coverage

2. ENROLLMENT INFORMATION ☐ Single ☐ Divorced ☐ Married

Relationship	Last Name, First Name, M.I.	Social Security No. Required	Sex	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other _____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No

Employee Home Address: Street, City, State, ZIP Code | County

Employee Home Phone ( ) | Employee Work Phone ( ) | Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) | Dependent Name(s)

3. MEDICAL INFORMATION ***(If yes, circle condition)***

*** Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.**

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name _____ due date ___/ ___/ ___
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition, cancer/tumor, disorder of the blood or immune system, stroke, aneurysm, diabetes **(list age of onset below)**, mental/nervous disorder, depression, alcohol or drug abuse/dependency, kidney, liver or pancreas disorder, ulcerative colitis, Crohn's disease, lupus, lung disorder, COPD, emphysema, arthritis, back/disk disorder, multiple sclerosis, muscular dystrophy or any other condition? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. LIFE AND DISABILITY INSURANCE

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability
☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability
☐ Optional Life: _____ x annual earnings OR $_____
☐ Current Income: $ _____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

☐ Anthem By Design® Short Term Disability BUY-UP
☐ Anthem By Design® Long Term Disability BUY-UP
☐ Anthem By Design® Basic Life BUY-UP
(Complete separate election form.)

Life Class

	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			_ _		
Contingent Beneficiary			_ _		

5. PLEASE READ THE TERMS IN SECTION 11 CAREFULLY BEFORE SIGNING, AND REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant signature | Please Print Name | Date / /

Enrollment Application

Group size 2-50 eligible employees Name: _____ SS#: _____ _____ _____

6. PLEASE COMPLETE ALL INFORMATION

Reason for application:
- ☐ New enrollment
- ☐ Open enrollment (N/A for Life coverage)
- ☐ Qualifying event (please complete date and reason)
  Event Date ____/ ____/ ____
  - ☐ Marriage ☐ Divorce
  - ☐ Birth of Child ☐ Adoption
  - ☐ Termed Employment ☐ Other
- ☐ COBRA
  Event _____ Date ____/ ____/ ____
- ☐ State Continuation ☐ Waiver

Group Name	Group number	Sub Group Number
Group Address		Employee Hire/Rehire Date (Full time) / /

Employee status	Hours working per Week	Occupation	Income reported by:
☐ Active ☐ Disabled ☐ Retired ☐ Other (please explain) _____	If not actively working, reason _____ Projected Return Date ____/ ____/ ____	Annual Salary	☐ W2 ☐ 1099 ☐ Other (please explain) _____

7. COVERAGE SELECTION *(Availability dependent upon your employer's offering)*

Medical Coverage
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Check the medical plan you are applying for:
- ☐ PPO
- ☐ Anthem Essential℠ PPO
- ☐ HMO
- ☐ Traditional
- ☐ Blue Access® Hospital Surgical PPO
- ☐ HDHP
- ☐ HDHP/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ PPO/PPO
  - ☐ Core
  - ☐ Buy Up
- ☐ Lumenos® Health Savings Account
- ☐ Lumenos® Health Reimbursement Account
- ☐ Lumenos® Health Incentive Account
- ☐ Lumenos® Health Incentive Account Plus

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Dental Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

Vision Coverage:
Please check one type:
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family
- ☐ No Coverage

1. If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.
2. A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.

8. WAIVER OF COVERAGE SECTION: *(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)*

NOTE: If waiving coverage, please complete this section. Section 5 must also be signed and dated.

Medical Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Dental Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Vision Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Life coverage declined for: ☐ Myself

Reason for Declining Coverage (check all that apply):
- ☐ Covered by spouse's group coverage - Carrier name and ID Number _____
- ☐ Enrolled in other Insurance provided by my employer - Carrier name and ID Number _____
- ☐ Enrolled in Individual coverage - Carrier name and ID Number _____
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare
- ☐ Other (Please explain) _____
- ☐ No coverage

9. PRIOR HEALTH INSURANCE INFORMATION *Prior Health Care Coverage During the past 2 years (including Anthem):*

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
	☐ Employee Only ☐ Employee + child(ren) ☐ Employee + spouse ☐ Family		/ /	/ /

10. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No

Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date
			/ /

Policy/Certificate Holder's Name	Social Security Number	Date of birth	Relationship to applicant	Family members covered by Medicare:
		/ /		

Medicare ID #	Part A effective date	Part B effective date	*Medicare eligibility reason (check all that apply)*
			☐ Age ☐ Disability ☐ ESRD: Onset Date _____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date
		/ /	/ /

ANTHEM USE ONLY Coordination of Benefits? ☐ Yes ☐ No Pre-ex (date)

Enrollment Application

Group size 2-50 eligible employees Name: _____ SS#: _____ _____ _____

11. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 5.***

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: 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 Blue Cross Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

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.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless required by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions.
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to enrollment. This exclusion may last up to 12 months from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a dependent that is enrolled in the plan prior to his/her 19th birthday.
   I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of creditable coverage from the prior Health Insurance Carrier.
   To obtain a certificate of creditable coverage: 1. Contact the Human Resources area of your prior employer and request a certificate of creditable coverage or other evidence of prior coverage, 2. Contact your prior insurance carrier and request a certificate of creditable coverage or, if necessary, requests the steps to obtain a certificate of creditable coverage, or 3. Contact Anthem at the number on your new identification card for assistance in obtaining a certificate of creditable coverage from your prior insurance carrier. Make sure you provide your current mailing address.
   Upon receipt of your certificate of creditable coverage, forward a copy to the address on the back of your new identification card.
4. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage).
   However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
   I also understand that my dependents and I may enroll under two additional circumstances:
   - Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
   - My dependent or I become eligible for a subsidy (state premium assistance program)

   In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 4 on page 1 and in Sections 6 through 10 on page 2 are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

By signing Section 5, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. ***Thank you for choosing Anthem Blue Cross and Blue Shield.***

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