

**Employer Application  
for Administrative Services  
Kentucky**



Please complete electronically, or in blue or black ink only. For more information about Anthem, its products and services, visit [anthem.com](http://anthem.com).

**Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respects to claims.**

Group no.  
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**Section 1: Company information**

<input type="checkbox"/> New enrollment <input type="checkbox"/> Renewal/Plan amendment		Benefit year <input type="checkbox"/> Calendar year <input type="checkbox"/> 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: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Limited Liability Company (LLC) <input type="checkbox"/> Labor union <input type="checkbox"/> Trust <input type="checkbox"/> Government unit/agency <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Will bargaining agreement participants be considered eligible employees? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Union name (attach copy of agreement)			Union no.		Contract expiration date

### 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 HSA  Blue Access PPO HRA (with Copay)  
 Blue Access (PPO)  Blue Access PPO HSA (with Copay)

**Large Group 100+ options**

Anthem Essential (PPO)  Blue Access PPO HSA  Blue Access PPO HRA  
 Blue Access (PPO)  Blue Access PPO HSA (with Copay)  Blue Access PPO HRA (with Copay)  
 Blue Preferred (HMO)  Blue Access PPO Deductible First HRA  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)  Commuter Parking  
 Limited-Purpose FSA (for dental and vision services)  Commuter Transit  
 Dependent Care FSA  No FSA coverage at this time

**Dental coverage**

Prime Essential Choice Quote ID: \_\_\_\_\_  Complete Essential Choice Quote ID: \_\_\_\_\_  
 Other: \_\_\_\_\_ 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
<b>Choose life product and group contribution percentage:</b> <input type="checkbox"/> None _____ % <input type="checkbox"/> Basic Life _____ % <input type="checkbox"/> Basic Life & AD&D _____ % <input type="checkbox"/> Basic Dependent Life _____ % <input type="checkbox"/> Supplemental/Voluntary Life and AD&D _____ % <input type="checkbox"/> Supplemental/Voluntary Dependent Life _____ %	<b>Choose disability product and group contribution percentage:</b> <input type="checkbox"/> None _____ % <input type="checkbox"/> Short Term Disability _____ % <input type="checkbox"/> Long Term Disability _____ % <input type="checkbox"/> Voluntary Short Term Disability _____ % <input type="checkbox"/> Voluntary Long Term Disability _____ %

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 <input type="checkbox"/> Yes <input type="checkbox"/> No			
Disability coverage <input type="checkbox"/> Yes <input type="checkbox"/> 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
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> 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)

**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 <b>X</b>	Date (MM/DD/YYYY)
Accepted by Anthem's Underwriting Department – Signature <b>X</b>	Date (MM/DD/YYYY)