Employee Enrollment Application
For 2–100 Employee Small Groups
Virginia

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

PPO health care plans are insurance products offered by Anthem Blue Cross and Blue Shield; HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc.

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.

Application completed for (check company that applies)
☐ Anthem Blue Cross and Blue Shield
☐ HealthKeepers, Inc.

Please complete in blue or black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)

Home address – Street and PO Box if applicable			

City	City/County	State	ZIP code

Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Secondary phone no.

Employee email address

Employer name	Group no. (if known)

Employer street address

City	State	ZIP code

Employment status ☐ Full time ☐ Part time ☐ Disabled ☐ Retired	Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment
☐ Family addition Event date: ____/____/____
☐ COBRA
☐ 12 Month State Continuation

Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Covered employee's Medicare entitlement
☐ Reduction in hours
☐ Divorce or legal separation
☐ Death

Note: For 12 Month State Continuation/COBRA applicants: Effective date of qualifying event: ____/____/____

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

Section C: Type of Coverage

1. Medical Coverage

Enter network, product and contract code selected:

Network – select one: ☐ KeyCare ☐ HealthKeepers ☐ HealthKeepers Open Access	Product	Contract code

Note for Lumenos Health Savings Account (HSA) enrollees:
If you enroll in a Lumenos HSA plan, Anthem/HealthKeepers will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

Enter product selected: _____ Contract code: _____

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

3. Vision Coverage

Enter product selected: _____ Contract code: _____

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + child(ren) ☐ Family

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse's 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.

Employee last name	First name	M.I.	
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self
Primary Care Physician (PCP) name		PCP ID no.	Existing patient? ☐ Yes ☐ No

Spouse or Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	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	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ 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	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ 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	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ 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:** ______			

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Section E: 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	Part B effective date	Medicare eligibility reason (check all that apply)
			☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

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

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

If yes to any of these questions, 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.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Section F: Waiver/Declining Coverage

Medical Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse or Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse or domestic partner's group coverage
- ☐ Enrolled in other Insurance –
  Please provide company name and plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse or domestic partner covered by employer's group medical coverage
- ☐ Medicare/Medicaid/TriCare
- ☐ Other – please explain: _____
- ☐ No coverage

Dental Coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse or Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse or domestic partner's group coverage
- ☐ Enrolled in other Insurance –
  Please provide company name and plan: _____
- ☐ Spouse or domestic partner covered by employer's group dental coverage
- ☐ Other – please explain: _____
- ☐ No coverage

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes.

Vision Coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse or Domestic Partner ☐ Dependent(s)

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further vision enrollment changes.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem/HealthKeepers as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, domestic partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild, domestic partner's child, foster child, or any other child for whom the employee has legal guardianship or court-ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of intellectual disability or physical handicap that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

Section G: Terms, Conditions and Authorizations — Continued

In signing this application I represent that:

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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

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

Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by HealthKeepers, Anthem Blue Cross and Blue Shield or by another carrier.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you 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 your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

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