Employee Change Form
For Small Groups
Virginia

PPO health care plans, including dental and vision coverage, are preferred provider organization insurance products offered by Anthem Blue Cross and Blue Shield (Anthem); HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. (HealthKeepers); Life and disability plans are insurance products offered by Anthem Life Insurance Company (Anthem Life).

Consult the Evidence of Coverage for complete coverage terms and conditions. For more information about Anthem, HealthKeepers, and Anthem Life, its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary.

Section A: General Information

Employer name		Group no.	Employee life class
Employee last name	Employee first name	M.I.	Employee Social Security no.[1] (required)

Section B: Employee Information — Required

Reason for change – Required. Select all that apply.

☐ Address change ☐ Add Spouse or Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Name change ☐ Cancel Spouse or Domestic Partner or dependent ☐ Cancel coverage
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Cancel products
☐ Change Life and or Disability classification from _______to______ ☐ Other:______________________________

Event reason - Required. Select all that apply.

☐ Open enrollment (not applicable for life and disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child/child placed for adoption
☐ Foster Child ☐ Step Child ☐ Loss of coverage ☐ Other insurance ☐ Death ☐ Termination ☐ Court ordered coverage
☐ Other- please explain: ____

Event date/Requested effective date- Required __________/______/_________ (MM/DD/YYYY)

Home address — Street and PO Box if applicable		City	State	ZIP code
Birthdate (MM/DD/YYYY): _______/_____/_______	Sex: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married ☐ Domestic Partner		
Primary phone no.	Occupation			
PCP name		PCP ID no.	Existing patient ☐ Yes ☐ No	

Email address: ____

For myself and any dependents, I'm providing my email address because I want to get information about my benefits by email or electronically. This may include my certificate or Evidence of Coverage, explanation of benefits, Evidence of Insurability underwriting documents, required notices, and helpful or personalized information to get the most out of my benefits. I will make sure Anthem/HealthKeepers/Anthem Life has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by providing my email address, information about my dependents may also be sent by email or electronically. I know I, or my enrolled dependents, can change our minds at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependents) will update our communication preferences by going to anthem.com or calling Member Services.

Section C: Family Information — Spouse or Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add
☐ Change
☐ Cancel

Event reason - Required. Select all that apply.

☐ Open enrollment (not applicable for life and disability products) ☐ Marriage ☐ Birth of child
☐ Adoption of child/child placed for adoption ☐ Foster Child ☐ Step Child ☐ Loss of coverage ☐ Other insurance ☐ Death
☐ Court ordered coverage ☐ Other- please explain: ____

Event date/Requested effective date- Required __________/______/_________ (MM/DD/YYYY)

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

Anthem Blue Cross and Blue Shield is the trade name of **Anthem Health Plans of Virginia, Inc**. **Anthem Blue Cross and Blue Shield**, and its affiliate **Healthkeepers, Inc.**, serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. Life and Disability products underwritten by **Anthem Life Insurance Company**, an independent licensee of the Blue Cross and Blue Shield Association.

Employee name: ____________________________ Social Security no.: _____/_____/_____

Spouse or Domestic Partner or Dependent Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant: ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other[2] If other, what is the relationship? ____________________

PCP name	PCP ID no.	Existing patient ☐ Yes ☐ No

Does the Spouse or Domestic Partner or dependent have a different address? ☐ Yes ☐ No
If yes, please enter:____

Section D: Plan/Type of Coverage

1. Medical Coverage

Medical product plan name:	Contract code, if known:

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

2. Dental Coverage

Dental product plan name:	Contract code, if known:

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

3. Vision Coverage

Vision product plan name:	Contract code, if known:

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

4. Life, Accidental Death and Dismemberment (AD&D), and Disability Coverage

☐ I am enrolling in my Employer's Life/AD&D and/or Disability plan(s) if any

☐ Basic Life and AD&D
☐ Basic Dependent
☐ Optional Supplemental/Voluntary Life and AD&D $ __________ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse or Domestic Partner $ __________ (Spouse or Domestic Partner amount)
☐ Optional Supplemental/Voluntary Dependent Life Child $ __________ (child amount)

☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income: $	Life and Disability class no.:

If selecting Short Term Disability coverage: Do you work in New York? ☐ Yes ☐ No Do you work in New Jersey? ☐ Yes ☐ No

Primary Beneficiary – Attach a separate sheet if necessary.

Last name	First name	M.I.	Relationship	Social Security no.	Percentage
Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary – Attach a separate sheet if necessary.

Last name	First name	M.I.	Relationship	Social Security no.	Percentage
Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

If an applicant's age at the time of application is at least 15 but less than 18, and the applicant lives with a parent, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.

Spouse or Domestic Partner signature X	Spouse or Domestic Partner name	Date (MM/DD/YYYY) / /

1 Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.
2 Eligibility subject to Evidence of Coverage.

Section E: Prior and Other Group Coverage

Is 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 (select all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease (ESRD): Onset date (MM/DD/YYYY) ____/_____/_____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____

Section F: 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 or Anthem Life 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 Anthem/Healthkeepers/Anthem Life; or
- Employees eligible for continuous coverage under state or federal laws.

Eligible dependent (for plans offered by Anthem/HealthKeepers/Anthem Life) (see Evidence of Coverage for complete dependent eligibility terms):

- Employee's Spouse, eligible Domestic Partner, or children age 26 or younger, 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. The age limit for enrolling a child is age 26. Coverage for a child will end on the last day of the month in which the child reaches age 26. For life coverage, only employee's Spouse or Domestic Partner, or children age 26 or younger, legally adopted children, and stepchildren are eligible.
- For all plans, including life, the age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of intellectual impairment 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 or impairment 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. ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A

CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent 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: If I enroll in a HSA plan, Anthem or HealthKeepers will facilitate the opening of a Health Savings Account in my name, if directed by my employer. 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 or HealthKeepers with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem or HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem or Healthkeepers with a written request to revoke my authorization at any time.

Life and/or Disability enrollees:
I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life Insurance Company (Anthem Life), having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, or about me, to give any and all such information to authorized representatives of Anthem Life, and including any mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, in certain circumstances, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights by writing to Anthem Life.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy or electronic copy is as valid as the original. I or my authorized representative is entitled to receive a copy of this authorization.

Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.

These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Sign here	Applicant signature X	Date (MM/DD/YYYY) / /
	Spouse or Domestic Partner signature X	Date (MM/DD/YYYY) / /

We’re here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here’s the English version: “You have the right to get help in your language for free. Just call the Member Services number on your ID card.” Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l’aide dans votre langue. Il vous suffit d’appeler le numéro réservé aux membres qui figure sur votre carte d’identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d’autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਿਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf