

Employee Change Form For 1-50 Employee Small Groups Virginia



Health care plans, including dental and vision coverage, offered by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. PPO health care plans are 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).

Instructions: If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing anthem.com.

Section A: General Information			
Employer name		Group no.	Employee life class
Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

Section B: Employee Information — Required			
Reason for change – Required. Check all that apply.			
<input type="checkbox"/> Address change	<input type="checkbox"/> Add spouse or Domestic Partner or dependent	<input type="checkbox"/> Enrollment in Medicare (Fill in Section E)	
<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel spouse or Domestic Partner or dependent	<input type="checkbox"/> Cancel coverage	
<input type="checkbox"/> Benefit change	<input type="checkbox"/> Change Primary Care Physician (PCP)	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Change Life and or Disability classification from _____ to _____			
Event reason - Required. Check all that apply.			
<input type="checkbox"/> Add	<input type="checkbox"/> Open enrollment (not applicable for life and disability products)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child
<input type="checkbox"/> Change	<input type="checkbox"/> Involuntary loss of coverage	<input type="checkbox"/> Other insurance	<input type="checkbox"/> Death <input type="checkbox"/> Divorce
<input type="checkbox"/> Cancel	<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
Primary phone no.	Secondary phone no.	Email address	
Primary Care Physician (PCP) name		PCP ID no.	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section C: Family Information — Spouse or Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.			
Event reason-Required. Check all that apply.			
<input type="checkbox"/> Add	<input type="checkbox"/> Open enrollment (not applicable for life and disability products)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child
<input type="checkbox"/> Change	<input type="checkbox"/> Involuntary loss of coverage	<input type="checkbox"/> Other insurance	<input type="checkbox"/> Death <input type="checkbox"/> Divorce
<input type="checkbox"/> Cancel	<input type="checkbox"/> Other- please explain: _____		
Event date/Requested effective date- Required			(MM/DD/YYYY)
Spouse or Domestic Partner last name		First name	M.I. Social Security no.*(required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
PCP Name		PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Spouse or Domestic Partner have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please enter:			

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

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate **HealthKeepers, Inc.** are independent licensees of the Blue Cross Blue Shield Association. Life and Disability products underwritten by **Anthem Life Insurance Company**, an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section C: Family Information — Continued

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel				Event reason-Required. Check all that apply. <input type="checkbox"/> Open enrollment (not applicable for life and disability products) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other- please explain: _____			
Event date/Requested effective date- Required				(MM/DD/YYYY)			
Dependent last name			First name		M.I.	Social Security no.*(required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is the relationship? _____		
PCP Name				PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, please enter:							

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel				Event reason-Required. Check all that apply. <input type="checkbox"/> Open enrollment (not applicable for life and disability products) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other- please explain: _____			
Event date/Requested effective date- Required				(MM/DD/YYYY)			
Dependent last name			First name		M.I.	Social Security no.*(required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is the relationship? _____		
PCP Name				PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, please enter:							

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel				Event reason-Required. Check all that apply. <input type="checkbox"/> Open enrollment (not applicable for life and disability products) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other- please explain: _____			
Event date/Requested effective date- Required				(MM/DD/YYYY)			
Dependent last name			First name		M.I.	Social Security no.*(required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is the relationship? _____		
PCP Name				PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, please enter:							

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Section D: Plan/Type of Coverage						
1. Medical Coverage						
Enter network name, product plan name and contract code selected:						
Network name		Product plan name		Contract code, if known		
Note for Health Savings Account (HSA) enrollees: If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.						
Member medical coverage — select one:						
<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee + Spouse or Domestic Partner				
<input type="checkbox"/> Employee + child(ren)		<input type="checkbox"/> Family				
2. Dental Coverage						
Product plan name				Contract code, if known		
Member dental coverage — select one:						
<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee + Spouse or Domestic Partner				
<input type="checkbox"/> Employee + child(ren)		<input type="checkbox"/> Family				
3. Vision Coverage						
Product plan name				Contract code, if known		
Member vision coverage — select one:						
<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee + Spouse or Domestic Partner				
<input type="checkbox"/> Employee + child(ren)		<input type="checkbox"/> Family				
4. Life, Accidental Death and Dismemberment (AD&D), and Disability Coverage						
<input type="checkbox"/> I am enrolling in my Employer's Life/AD&D and/or Disability plan(s) if any						
<input type="checkbox"/> Basic Life and AD&D				<input type="checkbox"/> Short Term Disability		
<input type="checkbox"/> Basic Dependent				<input type="checkbox"/> Long Term Disability		
<input type="checkbox"/> Optional Supplemental/Voluntary Life and AD&D		\$ _____ (employee amount)		<input type="checkbox"/> Voluntary Short Term Disability		
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Spouse or Domestic Partner		\$ _____ (spouse or domestic partner amount)		<input type="checkbox"/> Voluntary Long Term Disability		
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Child		\$ _____ (child amount)				
Current annual income		Occupation		Life and Disability class 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.						
Spouse or Domestic Partner signature			Spouse or Domestic Partner name		Date (MM/DD/YYYY)	
X						

Section E: Other 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) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> 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

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

If yes to any of these questions, please provide the following. If any coverage will remain in force once you enroll with Anthem, leave the End date blank.

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)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: End:
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: End:
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: End:
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> 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:

- 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 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 an unmarried child who cannot support himself or herself because of intellectual disability, mental illness, or physical incapacity 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. 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 certify each Social Security number listed on this application is correct.

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 agree to receive emails with supplemental information, such as newsletters, to help me get the most out of my plan. I agree to provide Anthem/HealthKeepers/Anthem Life with my most up to date email address. I know I can opt out or change my mind at any time by contacting Anthem/HealthKeepers/Anthem Life.

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 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: 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)

Get help in your language

Language Assistance Services



And Its Affiliate HealthKeepers, Inc.

Curious to know what all this says? We would be too. Here's the English version:

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1810). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1810). (TTY/TDD: 711)

Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግሎቶች ቁጥርን (855-748-1810) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1810). (TTY/TDD: 711)

Bassa

Ɔ jũ ké m̄ dyi gbo-kpá-kpá m̄ó b̄é m̄ ké c̄èè-d̄ε n̄ià ke m̄úin w̄o d̄é b̄ɔ̄-w̄eɪn w̄ùd̄ù d̄ò m̄ú ní, m̄ b̄éin ɔ zòò dyiìn d̄é Mébà jè gbo-gm̄ò Kpòè n̄òbà n̄ià ke <855-748-1810> d̄á d̄á m̄ú. M̄ se w̄íq̄í kàkò d̄ò p̄éin m̄. (TTY/TDD: 711)

Bengali

একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1810)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1810)請求免費協助。(TTY/TDD: 711)

Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضاء به شماره (855-748-1810) تماس بگیرید. (TTY/TDD: 711)

French

Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1810. (TTY/TDD: 711)

German

Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-748-1810). (TTY/TDD: 711)

Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-748-1810) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Igbo

Ọ bụrụ na ị chọrọ enyemaka ịi ghọta dọkumentị a n'asụsụ dị iche, ị nwere ike ịrịọ ya na akwụghị ụgwọ ọ bụla ọzọ site na ịkpọ nọmba Ọrụ Onye Otu (855-748-1810). (TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1810)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1810). (TTY/TDD: 711)

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1810). (TTY/TDD: 711)

Urdu

تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کر کے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1810)

Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-748-1810). (TTY/TDD: 711)

Yoruba

Tí o bá nílò ìrànwọ́ kí àkọsílẹ̀ yíí le yé ọ ní èdè míràn, o le bèrè rẹ láísí àfikún owó nípa pípe Nọmbà Àwọn ọpèsè ọmọ-ẹgbé (855-748-1810). (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling [1-800-368-1019](tel:1-800-368-1019) (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.