Employee Enrollment Application For Small Groups Virginia

Anthem And Its Affiliate HealthKeepers, Inc.

Anthem Life

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).

The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application. Please complete in black ink only.

Application completed for (select the company that applies):
☐ Anthem Blue Cross and Blue Shield ☑ HealthKeepers, Inc. ☐ Anthem Life Insurance Company

Section A: Application Type

Select one: ☑ New enrollment ☐ Open enrollment (not applicable for Life or Disability) ☐ COBRA ☐ Family addition
☐ Rehire date: (MM/DD/YYYY) ____/____/____ ☐ 12 Month State Continuation effective date: (MM/DD/YYYY) ____/____/____

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

Qualifying event date: (MM/DD/YYYY) ____/____ /_____

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required) / /
Home address - Street and PO Box if applicable	City	State	ZIP code
County	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Employee email address
Occupation	Employer name		Group no. (if known)
Employer street address	City	State	ZIP code

Employment status	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
☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired	/ /	/ /	/ /	

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

Section C: Type of Coverage

1. Medical Coverage

Enter network, product and medical contract code selected:

Network – Select one:	Product	Medical contract code
☐ KeyCare ☐ HealthKeepers ☐ HealthKeepers Open Access ☐ HealthKeepers Pathway	Bronze Silver Gold	

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 Account in your name, if directed by your employer.

If your employer/group offers EPO coverage, 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 in and out-of-network providers. This may be a "preferred provider organization" or "PPO" plan offered by Anthem or a "point-of-service" or "POS" plan offered by HealthKeepers, Inc.

Member medical coverage – select one:
☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage[2]

1 Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.
2 If waiving Medical, Dental and/or Vision coverage for employee and/or any eligible family members, you must complete section F.

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

2. Dental Coverage – Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Anthem Dental Prime, Anthem Dental Complete, and Anthem Essential Choice with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Dental product plan name:	Contract code, if known:

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage[2]

3. Vision Coverage – Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Vision product plan name:	Contract code, if known:

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage[2]

4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage – A minimum of two employees must enroll.

☐ Basic Life and AD&D ☐ Basic Dependent Life ☐ 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.	Birthdate (MM/DD/YYYY) / /	Social Security no. / /	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY) / /	Social Security no. / /	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY) / /	Social Security no. / /	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY) / /	Social Security no. / /	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY) / /	Social Security no. / /	Relationship to applicant
Address				Percentage to be paid to beneficiary	

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

2 If waiving Medical, Dental and/or Vision coverage for employee and/or any eligible family members, you must complete section F.

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

Section D: Coverage Information – All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.

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, or 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): / /	
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.[1] (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.[1] (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.[1] (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: _____			

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

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 ☐ 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: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______

Section F: Waiver/Declining Coverage – Proof of coverage will be required. (Proof of coverage not applicable for Life and Disability.)

Type of coverage/Declined for – Select all that apply.		**Reason for declining/refusing coverage –** Select all that apply.
☐ Employee	☐ Medical ☐ Dental ☐ Vision ☐ *Life/AD&D (Spouse or Domestic Partner and Dependent coverage not available if life coverage is waived/declined) ☐ Short Term Disability ☐ Long Term Disability ☐ Optional Supplemental/Voluntary Life ☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability	☐ No coverage ☐ Covered by Spouse's or Domestic Partner's group coverage ☐ Spouse or Domestic Partner covered by employer's group medical coverage ☐ Enrolled in individual coverage ☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan: ________________________________ ☐ Other — please explain: ________________________________
☐ Spouse or Domestic Partner	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life ☐ Optional Supplemental/Voluntary Dependent Life	
☐ Dependent(s)	☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life ☐ Optional Supplemental/Voluntary Dependent Life List name of dependents to be waived: ________________________________	

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant X	Printed name	Today's date (MM/DD/YYYY) / /

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/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 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 (for plans offered by Anthem/HealthKeepers):

- 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. 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.

Special Enrollment Rights For Medical Coverage Only

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.

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.

I agree to receive emails with supplemental information, such as newsletters, for myself and my dependents, to help me get the most out of our plan. I agree to provide Anthem/HealthKeepers/Anthem Life with my most up to date email address. I know I, or my enrolled dependents, can opt out or change our minds 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/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.

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

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) / /