Employee Enrollment Application For Small Groups Virginia

Anthem And Its Affiliate HealthKeepers, Inc.

AnthemLife

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.

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.

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 (not applicable for Life or Disability)

☐ Covered employee's Medicare entitlement ☐ Death ☐ Reduction in hours
☐ Loss of dependent child status ☐ Left employment ☐ Loss of coverage

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	Primary phone no.	Marital status ☐ Single ☐ Married ☐ Domestic Partner	
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: _____

Employee 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.

1 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 medical contract code selected:

Network – Select one:	Product	Medical contract code
☐ KeyCare ☐ Pathway Tiered Hospital ☐ HealthKeepers	Bronze Silver Gold Platinum	

Note for Anthem Health Savings Account (HSA) enrollees:
If you enroll in an Anthem 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 Exclusive Provider Organization (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

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

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

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

☐ 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		/ /

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[2] 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[2] 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.
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: ___/_____/_____
	☐ 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, to decline this coverage. I elect 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/Anthem Life) (see Evidence of Coverage for complete dependent eligibility terms):

- 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 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 a 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. 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 (see Evidence of Coverage for complete 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.

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.

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 applicant's 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 iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ 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