

Employee Change Form Application



Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections.

Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing www.anthem.com. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

1. Employer/Group Use: Employer Name and Address:									
Group #	Sub-group #/Life Division #	Request Effective Date			Life Classification		Applicant #/Dept. name		
Anthem use:	Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)	
		/ /	/ /	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	

2. Reason for Change		3. Type of Coverage/Plan				
Event date ____/____/____		Health Coverage		Dental Coverage	Vision Coverage	
<input type="checkbox"/> Address <input type="checkbox"/> Change Life Beneficiary <input type="checkbox"/> Change Life Classification <input type="checkbox"/> Enrollment in Medicare (see section 7) <input type="checkbox"/> Cancel/Waiving Coverage (Refer to section 9) <input type="checkbox"/> Conversion		<input type="checkbox"/> Benefit change <input type="checkbox"/> Cancel dependent <input type="checkbox"/> PCP change <input type="checkbox"/> Name change <input type="checkbox"/> Other _____		<input type="checkbox"/> HMO* <input type="checkbox"/> Blue Priority SM * (*Ohio only - a health insuring corporation product or "HIC") <input type="checkbox"/> Lumenos, Health Savings Account <input type="checkbox"/> Lumenos, Health Reimbursement Account <input type="checkbox"/> Lumenos, Health Incentive Account <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	<input type="checkbox"/> PPO _____ <input type="checkbox"/> Traditional _____ (Indiana and Ohio only) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	<input type="checkbox"/> Vision _____ <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage
		<input type="checkbox"/> Life (see section 6) Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.				

4. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. (SS# required for Lumenos, Health Savings Account)											
Last name		First name, M.I.		Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	
Home address				City		State		Zip code		County (KY residents include Municipality)	
Hours worked per week		Anthem PCP name and address*				Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If PCP is a change, please indicate the reason for the change.											

5. Family Information Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.) * Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.											
1 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name				First name, M.I.					
Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change			
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)											
Anthem PCP name and address*						Anthem PCP ID number*			New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If PCP is a change, please indicate the reason for the change.											

2 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name				First name, M.I.					
Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change			
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)											
Anthem PCP name and address*						Anthem PCP ID number*			New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If PCP is a change, please indicate the reason for the change.											

3 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name				First name, M.I.					
Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change			
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)											
Anthem PCP name and address*						Anthem PCP ID number*			New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If PCP is a change, please indicate the reason for the change.											

6. Life and Disability Insurance											
<input type="checkbox"/> Basic Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> Supplemental Life: _____ x annual earnings OR \$ _____ <input type="checkbox"/> Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		<input type="checkbox"/> Basic AD&D <input type="checkbox"/> Supplemental AD&D <input type="checkbox"/> Long Term Disability _____%		<input type="checkbox"/> Short Term Disability _____% <input type="checkbox"/> Long Term Disability _____%		<input type="checkbox"/> Anthem By Design Short Term Disability-BUY UP <input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP <input type="checkbox"/> Anthem By Design Basic Life-BUY UP (Complete separate election form)		Are you currently actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason: _____			
Primary Beneficiary		Last name		First name, M.I.		Social Security #		Relationship to applicant		Age	
Contingent Beneficiary		Last name		First name, M.I.		Social Security #		Relationship to applicant		Age	

Signature required on the reverse side of this form.

7. Other Health Coverage Please check one: YES (complete below) NO
 On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number	Effective date / /
Policy/certificate holder's name	Social security number - -	Date of birth / /	Relationship to applicant

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /	

Reason for Medicare entitlement:
 Age Disability ESRD & Disability End Stage Renal Disease (ESRD)

8. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

- I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
- I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
- I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
- I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions, (Ohio only – unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
- I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
- Ohio: If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- THIS PARAGRAPH APPLIES ONLY TO MEMBERS OF OHIO GROUPS, AND DOES NOT APPLY TO MEMBERS OF INDIANA OR KENTUCKY GROUPS:** I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 & 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Kentucky: Any person who Knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Applicant Signature _____ Date / /

9. Waiver of coverage for employee and/or any eligible dependent not enrolling

Check all that apply. Waiving: Health Dental Vision Life All

Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)

Check all that apply. Waiving: Health Dental Vision Life All

Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)

Check all that apply. Waiving: Health Dental Vision Life All

Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)

Check all that apply. Waiving: Health Dental Vision Life All

Name of person waiving	Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)

Check all that apply

I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption. I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I certify that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, 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.

Applicant signature _____ Date / /

Life and disability products are underwritten by Anthem Life Insurance Company
 In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
 In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. © Registered marks Blue Cross and Blue Shield Association.