Employee Change Form Application

Anthem.

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

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 Use: Employer Name and Address:			
Group #	Sub-group #	Request Effective Date / /	Applicant #/Dept. name

Anthem use: Plan	Health Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	/ /

2. Reason for Change

Event date ___/___/___

- ☐ Address
- ☐ Enrollment in Medicare
- ☐ Cancel / Waiving Coverage (see section 8)
- ☐ Conversion
- ☐ Benefit change
- ☐ Cancel dependent
- ☐ PCP change
- ☐ Name change
- ☐ Other _____

3. Type of Coverage/Plan

Health Coverage	*Dental Coverage*	*Vision Coverage*
☐ HMO* (not applicable to Ohio)	☐ PPO _____	☐ Vision _____
☐ PPO _____ ☐ POS* ☐ Blue Traditional*	☐ Traditional (Indiana and Ohio only)	
☐ EPO (Ohio only)		
☐ Employee only	☐ Employee only	☐ Employee only
☐ Employee + spouse	☐ Employee + spouse	☐ Employee + spouse
☐ Employee + child(ren)	☐ Employee + child(ren)	☐ Employee + child(ren)
☐ Family coverage	☐ Family coverage	☐ Family coverage
☐ No coverage	☐ No coverage	☐ No coverage

4. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	☐ Single ☐ Divorced ☐ 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? ☐ Yes ☐ 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 for HMO or POS products.*

1 ☐ Change ☐ Cancel	Last name	First name, M.I.

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

2 ☐ Change ☐ Cancel	Last name	First name, M.I.

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

3 ☐ Change ☐ Cancel	Last name	First name, M.I.

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

Signature required on the reverse side of this form.

6. 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)

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

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit 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.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application 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.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment in the benefit plan. 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 benefit rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission of cancellation of my benefits.

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 / /

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

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

Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

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

Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

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

Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

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Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

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

Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #)	☐ Other carrier (give name, ID #)

I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits 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 benefit booklet, 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.

Applicant signature	Date / /