Employee Enrollment Application

Anthem

Your Anthem enrollment application is inside.

It is essential that you read it carefully and

complete all the necessary sections.

If you are a new enrollee:

a) applying for health benefits, please complete sections 2, 4, 5, 6, and 9. Your signature is required in Section 9.

b) waiving any or all benefits, please complete sections 2, 5 and 10. Your signature is required in Section 10.

If you are adding a dependent(s),
complete section 3 in addition to the above.

It is important that you read and understand the Significant Terms, Conditions and Authorizations in Section 9.

Thanks for choosing Anthem

Blue Cross and Blue Shield.

Note: *You may be required to supply additional information.*

www.anthem.com

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

A-77 7/07 ***LG-ASO***

Enrollment Application

Anthem

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

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.* 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:	Eastern Kentucky University 521 Lancaster Ave. Richmond, KY 40475					
Group #	Sub-group #		Request. Effective Date		Applicant #/Dept. name	
W29641			/ /			
Anthem use: Plan	Health Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	/ /

2. Reason for Application

☐ New enrollment
☐ Waiver
☐ Annual open enrollment
☐ COBRA
☐ Conversion
Qualifying event _____ Event date ___/___/___
☐ New hire
☐ Rehire (date) ___/ ___/___
☐ Add dependent (see section 3)

3. Status Change/Event

Event date ___/ ___/___
☐ Marriage
☐ Birth
☐ Adoption*
☐ Legal guardianship*
☐ Other _____
**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage
Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

☐ PPO1000
☐ PPO2000
☐ CDHP

☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage

5. 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 / /	Age	Sex ☐ M ☐ F	Social Security # (SS# required for Lumenos, Health Savings Account) - -	☐ Single ☐ Divorced ☐ Married

Home address	City	State	Zip code	County (KY residents include Municipality)

Home telephone ( ) -	Business telephone ( ) -	eMail Address

Are you: Retired? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	Hospitalized? ☐ Yes ☐ No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ☐ W2 ☐ 1099 ☐ Other:_____

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

6. Family Information *Spouse and dependents to be enrolled. (Attach a separate sheet if necessary.) *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

1 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____ | Fulltime student? ☐ Yes ☐ No

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

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

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

2 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____ | Fulltime student? ☐ Yes ☐ No

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

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

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

3 Last name	First name, M.I.	Relationship ☐ Spouse ☐ Son to applicant ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)
4 Last name	First name, M.I.	Relationship ☐ Spouse ☐ Son to applicant ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

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. 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 benefits or rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or 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.

Your health benefit plan will be administered by one of the following companies based upon the state in which your employer is located:

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 Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

In Wisconsin: Blue Cross Blue Shield of Wisconsin (''BCBSWi'') administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (''Compcare'') administers the HMO and POS policies.

9. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature	Date

Please complete the waiver if you and / or any eligible dependent are not enrolling.

10. 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 #)

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 #)

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