

Employee Enrollment Application For 1-50 Employee Small Groups Ohio



You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in blue or black ink only.

Section A: Employee Information					
Last name		First name		M.I.	Social Security no. * (required)
Home address – Street and PO Box if applicable					
City			County		State ZIP code
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner			Primary phone no.		Secondary phone no.
Employee email address					
Employer name					Group no. (if known)
Employer street address					
City					State ZIP code
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired		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
Section B: Application Type					
Select one					
<input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment (not applicable for Life and Disability)		<input type="checkbox"/> COBRA – Select qualifying event <input type="checkbox"/> Left employment <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Medicare		<input type="checkbox"/> Reduction in hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Covered employee's Medicare entitlement	
				Death <input type="checkbox"/> Qualifying event date _____	

*Anthem is required by the Internal Revenue Service to collect this information.

Employee name

Social Security no.

Section C: Type of Coverage

1. Medical Coverage – select one plan option

Table with 4 columns: PPO Plans, Anthem Gold, Anthem Silver, Anthem Bronze. Each column lists various insurance plan options with checkboxes.

Other: _____

Member medical coverage – select one: Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family

Contract Code

Please indicate the contract code for the medical plan selected. Contract code: _____

2. Dental Coverage – select plan options. Please ask your employer which dental options are available before checking your selection.

PPO dental plans – These plans include Pediatric Dental Essential Health Benefits.

Anthem Dental Family Anthem Dental Family Enhanced Anthem Dental Pediatric Other: _____

PPO Dental Prime and Dental Complete plans – These plans do NOT include Pediatric Dental Essential Health Benefits.

Table with 4 columns: Value, Classic, Enhanced, Voluntary. Each column lists dental plan options with checkboxes.

Member dental coverage – select one: Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family No coverage
If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract Codes

Please indicate the contract code(s) for the dental plan(s) selected. Contract code 1: _____ Contract code 2: _____

3. Vision Coverage – select one plan option

Table with 2 columns: Full Service, Materials Only Plans. Each column lists vision plan options with checkboxes.

Member vision coverage – select one: Employee only Employee + Spouse/Domestic Partner Employee + child(ren) Family

Contract Code

Please indicate the contract code for the vision plan selected. Contract code: _____

Employee name	Social Security no.
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4. Life and Disability Coverage – A minimum of two subscribers must enroll

If you select Life and/or Disability coverage over the guarantee issue amount or are a late entrant an Evidence of Insurability form will be sent to you to complete.

<input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Basic Dependent Life <input type="checkbox"/> Optional/Voluntary Life & AD&D <input type="checkbox"/> Optional/Voluntary Dependent Life	<input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary Short-Term Disability <input type="checkbox"/> Voluntary Long-Term Disability	Life Class
Current income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		Occupation

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.

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature X	Spouse name	Date
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Employee name	Social Security no.
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Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self		
Primary Care Physician (PCP) name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Spouse/Domestic Partner last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Dependent last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____				
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____							
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Dependent last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____				
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____							
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Dependent last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____				
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____							
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No							

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

Employee name

Social Security no.

Section E: Other Group CoverageAre you or anyone applying for coverage currently eligible for Medicare? Yes No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare? Yes NoOn the day your coverage begins, will you or a family member be covered by other health coverage? Yes NoOn the day your coverage begins, will you or a family member be covered by other dental coverage? Yes No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental				Start: _____ End: _____

Employee name	Social Security no.
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Section F: Waiver/Declining Coverage

Medical coverage declined for – check all that apply: Myself Spouse/Domestic Partner Dependent(s)

Dental coverage declined for – check all that apply: Myself Spouse/Domestic Partner Dependent(s)

Vision coverage declined for – check all that apply: Myself Spouse/Domestic Partner Dependent(s)

***Life/AD&D coverage declined for:** Myself
 Spouse, Domestic Partner and Dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: Spouse/Domestic Partner and Dependents

Short Term Disability coverage declined for: Myself

Long Term Disability coverage declined for: Myself

Reason for declining coverage – check all that apply:

Covered by spouse's group coverage
 Enrolled in other Insurance provided by my employer
 Enrolled in Individual coverage
 Spouse covered by employer's group medical coverage
 Medicare/Medicaid/VA
 Other – please explain: _____
 No coverage

*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	Social Security no.	Date (MM/DD/YYYY)
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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 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 the Company(ies); 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:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- Employee must complete an affidavit of dependency for Ohio group coverage if you are applying for coverage for an unmarried child who has reached the limiting age of the policy and is requesting either an extension or reinstatement of coverage until the end of the month in which the child reaches age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity 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. Any person who, with 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 is guilty of insurance fraud. I understand all benefits are subject to conditions stated in the Group Agreement and coverage document.

Employee name

Social Security no.

Section G: Terms, Conditions and Authorizations – Continued

In signing this application I represent 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 understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.

I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

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 with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Ohio: 3904.04 Notice of Information Practices:

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 and 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.

Fraud Notice

Any person who, with 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 is guilty of insurance fraud.

Sign here	Signature of applicant* or legal representative X	Date (MM/DD/YYYY)
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*(or Custodial Parent's or Guardian's signature if applicant is under age 18)

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) 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.

Employee name

Social Security no.



Underwritten by Community Insurance Company

