

Employer Enrollment Application For 1-50 Employee Small Groups Ohio



Please complete in blue or black ink only.

Section A: Company Information						
Company name				Employer tax ID no. (required)		
Company street address						
City			County		State	
Billing address – If different from above						
City			County		State	
Is this for coverage as a member of an association plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, association name: _____						
Organization type: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Government unit/agency <input type="checkbox"/> Limited Liability Company (LLC) <input type="checkbox"/> Labor union trust <input type="checkbox"/> Other: _____						
SIC code – Required	Type of business (be specific)				Date business established	
Head of firm			Company contact name			
Company contact title			Primary phone no.		Fax no.	
Email address						
Additional company contact name				Title		
Primary phone no.		Fax no.				
Email address						
Does group have a cafeteria plan under IRS Section 125? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal revenue Code Section 414? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.						
Open Enrollment						
Our standard open enrollment period is at least 31 days before the Group's renewal date and 31 days after, which is held no more often than once in any 12 consecutive months. The open enrollment period does not apply to Life and Disability products.						
Section B: Application Type						
<input type="checkbox"/> New enrollment					Requested effective date (MM/DD/YYYY)	

Section C: Type of Coverage

1. Medical Coverage – check all that apply

PPO Plans	Anthem Gold	Anthem Silver	Anthem Bronze	
Blue Access	<input type="checkbox"/> 500/20%/3500 <input type="checkbox"/> 1000/20%/3750 <input type="checkbox"/> 1000/20%/4500 <input type="checkbox"/> 1000/30%/4500 Plus <input type="checkbox"/> 1500/20%/4000 <input type="checkbox"/> 1750/0%/3425 w/HSA <input type="checkbox"/> 2000/0%/2500 w/HSA <input type="checkbox"/> 2000/20%/4000 <input type="checkbox"/> 2500/0%/3500 <input type="checkbox"/> 2500/20%/4250 <input type="checkbox"/> 3500/0%/4250 <input type="checkbox"/> 3750/0%/4750 <input type="checkbox"/> 1000/20%/4000 Focus <input type="checkbox"/> 2000/0%/3000 Focus w/HSA <input type="checkbox"/> 2250/0%/2250 Plus w/HSA	<input type="checkbox"/> 2000/50%/6350 <input type="checkbox"/> 2000/50%/6350 P2 <input type="checkbox"/> 2600E/20%/4500 Plus w/HSA <input type="checkbox"/> 2600EC/30%/5000 w/HSA <input type="checkbox"/> 3000EC/0%/3500 w/HSA <input type="checkbox"/> 3000/20%/6850 <input type="checkbox"/> 3000/30%/6500 Plus <input type="checkbox"/> 3500E/0%/3500 w/HSA <input type="checkbox"/> 3500E/0%/4500 w/HSA <input type="checkbox"/> 3500E/0%/5000 w/HSA <input type="checkbox"/> 5000/20%/6850	<input type="checkbox"/> 6000/0%/6850 <input type="checkbox"/> 2600E/30%/4750 w/HSA <input type="checkbox"/> 3000/20%/6800 Focus <input type="checkbox"/> 5000/0%/6800 Focus <input type="checkbox"/> 5000/20%/6800 Focus	<input type="checkbox"/> 3500E/50%/6450 w/HSA <input type="checkbox"/> 5000EC/20%/6350 w/HSA <input type="checkbox"/> 5000EC/20%/6450 w/HSA <input type="checkbox"/> 5000EC/20%/6550 Plus w/HSA <input type="checkbox"/> 5250EC/0%/6550 Plus w/HSA <input type="checkbox"/> 5500E/0%/6450 w/HSA <input type="checkbox"/> 6000E/0%/6000 w/HSA <input type="checkbox"/> 6550E/0%/6550 w/HSA <input type="checkbox"/> 4500E/50%/6350 Focus w/HSA <input type="checkbox"/> 5500EC/30%/6500 Focus w/HSA <input type="checkbox"/> 6300/30%/6850 Focus

Other: _____

Choose your medical contribution for each month – only one choice is allowed.

Contribution option 1: Traditional option – We will contribute (50% to 100%): _____% per employee _____% per dependent (optional)

Contribution option 2: Percentage of plan option – We will contribute: _____% to _____ plan)

For Health Savings Account (HSA) plans:

- Group will establish Health Savings Account (HSA) with Anthem facilitating with a banking services provider.
- Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

HSA administrator name	Phone no.	Email address
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Riders/Optional Benefits – select additional optional benefits

- Calendar Year
- Plan Year
- Alliances

Contract Codes – indicate the contract code(s) for the plan(s) selected. The codes can be found on the proposal/quote output.

Contract Code	Contract Code	Contract Code
1.	4.	7.
2.	5.	8.
3.	6.	9.

2. Dental Coverage – check all that apply

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

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

Choose your dental contribution for each month: ____% per employee ____% per dependent (optional)

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

Value	Classic	Enhanced	Voluntary	
<input type="checkbox"/> Value Prime OH-1A <input type="checkbox"/> Other: _____	<input type="checkbox"/> Classic Prime OH-2A <input type="checkbox"/> Classic Prime OH-2B <input type="checkbox"/> Classic Prime OH-2C <input type="checkbox"/> Classic Prime OH-2D <input type="checkbox"/> Classic Prime OH-2E <input type="checkbox"/> Classic Prime OH-2F <input type="checkbox"/> Classic Prime OH-2G <input type="checkbox"/> Classic Prime OH-2H <input type="checkbox"/> Classic Prime OH-2J <input type="checkbox"/> Classic Prime OH-2K <input type="checkbox"/> Classic Prime OH-2L <input type="checkbox"/> Classic Prime OH-2M <input type="checkbox"/> Classic Complete OH-2AA <input type="checkbox"/> Classic Complete OH-2AB <input type="checkbox"/> Classic Complete OH-2AC <input type="checkbox"/> Classic Complete OH-2AD	<input type="checkbox"/> Classic Complete OH-2AE <input type="checkbox"/> Classic Complete OH-2N <input type="checkbox"/> Classic Complete OH-2P <input type="checkbox"/> Classic Complete OH-2Q <input type="checkbox"/> Classic Complete OH-2R <input type="checkbox"/> Classic Complete OH-2S <input type="checkbox"/> Classic Complete OH-2T <input type="checkbox"/> Classic Complete OH-2U <input type="checkbox"/> Classic Complete OH-2V <input type="checkbox"/> Classic Complete OH-2W <input type="checkbox"/> Classic Complete OH-2X <input type="checkbox"/> Classic Complete OH-2Y <input type="checkbox"/> Classic Complete OH-2Z <input type="checkbox"/> Other: _____	<input type="checkbox"/> Enhanced Prime OH-3A <input type="checkbox"/> Enhanced Prime OH-3B <input type="checkbox"/> Enhanced Complete OH-3C <input type="checkbox"/> Enhanced Complete OH-3D <input type="checkbox"/> Enhanced Complete OH-3E <input type="checkbox"/> Enhanced Complete OH-3F <input type="checkbox"/> Enhanced Complete OH-3G <input type="checkbox"/> Enhanced Complete OH-3H <input type="checkbox"/> Enhanced Complete OH-3J <input type="checkbox"/> Enhanced Complete OH-3K <input type="checkbox"/> Enhanced Complete OH-3L <input type="checkbox"/> Enhanced Complete OH-3M <input type="checkbox"/> Enhanced Complete OH-3N <input type="checkbox"/> Enhanced Complete OH-3P <input type="checkbox"/> Other: _____	<input type="checkbox"/> Voluntary Prime OH-4B <input type="checkbox"/> Voluntary Complete OH-4A <input type="checkbox"/> Voluntary Complete OH-4C <input type="checkbox"/> Voluntary Complete OH-4D <input type="checkbox"/> Voluntary Complete OH-4E <input type="checkbox"/> Voluntary Complete OH-4F <input type="checkbox"/> Voluntary Complete OH-4G <input type="checkbox"/> Other: _____

Contract Codes – Indicate the contract code(s) for the dental plan(s) selected.

Contract code: 1. _____ 2. _____

Is this plan intended to replace any existing group dental coverage? Yes No

If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective date	Proposed termination date

Voluntary plan participation

5-50 Eligible Employees: A minimum of five employees must enroll (there is no participation-percentage requirement). Dual Option is not available for Voluntary plans.

Value, Classic and Enhanced plan participation

2-4 Eligible Employees: 100% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll.

5-50 Eligible Employees: A minimum of 75% of employees not covered by another dental plan are required to enroll. A minimum of two must enroll. For orthodontia, a minimum of ten (10) employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.

Medical Lock (Packaged Enrollment): All members enrolled in an Anthem medical plan must enroll in Anthem dental. Dental tiering must be identical on the medical and dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

3. Vision Coverage – select one plan option

Full Service				Materials Only Plans
<input type="checkbox"/> Anthem Blue View Vision A1	<input type="checkbox"/> Anthem Blue View Vision B1	<input type="checkbox"/> Anthem Blue View Vision C1	<input type="checkbox"/> Anthem Blue View Vision C6	<input type="checkbox"/> Anthem Blue View Vision M01
<input type="checkbox"/> Anthem Blue View Vision A2	<input type="checkbox"/> Anthem Blue View Vision B2	<input type="checkbox"/> Anthem Blue View Vision C2	<input type="checkbox"/> Anthem Blue View Vision C7	<input type="checkbox"/> Anthem Blue View Vision M02
<input type="checkbox"/> Anthem Blue View Vision A3	<input type="checkbox"/> Anthem Blue View Vision B3	<input type="checkbox"/> Anthem Blue View Vision C3	<input type="checkbox"/> Anthem Blue View Vision C8	<input type="checkbox"/> Anthem Blue View Vision M03
<input type="checkbox"/> Anthem Blue View Vision A4	<input type="checkbox"/> Anthem Blue View Vision B4	<input type="checkbox"/> Anthem Blue View Vision C4	<input type="checkbox"/> Anthem Blue View Vision C9	<input type="checkbox"/> Anthem Blue View Vision M04
<input type="checkbox"/> Anthem Blue View Vision A5	<input type="checkbox"/> Anthem Blue View Vision B5	<input type="checkbox"/> Anthem Blue View Vision C5		<input type="checkbox"/> Anthem Blue View Vision M05
<input type="checkbox"/> Anthem Blue View Vision A6	<input type="checkbox"/> Anthem Blue View Vision B6			<input type="checkbox"/> Anthem Blue View Vision M06
				<input type="checkbox"/> None

Choose your vision contribution for each month: ____% per employee ____% per dependent (optional)

Contract Code – Indicate the contract code for the vision plan selected.

Contract code: 1. _____

Section D: Eligibility

<p>1. Total number of employees (including employed owners/officers): <input style="width: 40px;" type="text"/></p> <p>2. Number of eligible full-time employees (minimum 30 hours per week): <input style="width: 40px;" type="text"/></p> <p>3. Number of employees enrolling in:</p> <p>Medical: <input style="width: 40px;" type="text"/> Dental: <input style="width: 40px;" type="text"/></p> <p>Vision: <input style="width: 40px;" type="text"/> Life/Disability: <input style="width: 40px;" type="text"/></p> <p>4. Number of eligible DECLINING employees: <input style="width: 40px;" type="text"/></p> <p>5. Number of INELIGIBLE employees: <input style="width: 40px;" type="text"/></p> <p>6. Probationary period/waiting period for new employees:</p> <p><input type="checkbox"/> None <input type="checkbox"/> First of month after hire date</p> <p><input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days</p> <p>7. New eligible enrollees will become effective on:</p> <p><input type="checkbox"/> First of month following completion of waiting period/probationary period</p> <p><input type="checkbox"/> Day following completion of waiting period/probationary periods (required for 90 day waiting period)</p> <p>The standard effective date is first of the month following the waiting period/probationary period.</p>	<p>8. Do you wish to offer coverage for domestic partners?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Under the Medicare Secondary Payer rules, which one applies for your group?</p> <p><input type="checkbox"/> Medicare is primary (less than 20 employees)</p> <p><input type="checkbox"/> Anthem Blue Cross and Blue Shield is primary (20 or more employees)</p> <p>Anthem Blue Cross and Blue Shield is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.</p> <p>10. Is your company currently subject to COBRA (employed 20 or more total employees on at least 50% of the working days in the previous calendar year)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Eligibility and Waiting Period

Is the eligibility period for Life and/or Disability the same as the Anthem medical policy eligibility period? Yes No

Enter the Life and Disability eligibility period below if it differs from the Anthem medical policy eligibility period.

Eligible full-time employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible full-time employees is 30 hours unless otherwise indicated.

<p>The waiting period for individuals employed on or before the effective date will be:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> <input style="width: 40px;" type="text"/> days of continuous employment</p> <p><input type="checkbox"/> First premium due date following <input style="width: 40px;" type="text"/> days of continuous employment</p>	<p>The waiting period for individuals employed on or after the effective date will be:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> <input style="width: 40px;" type="text"/> days of continuous employment</p> <p><input type="checkbox"/> First premium due date following <input style="width: 40px;" type="text"/> days of continuous employment</p>
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Does any class(es) have a different waiting period? Yes No

If yes, please describe: _____

Section E: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section F: General Agreement

Please read this section carefully before signing the application.

Please check the box that applies:

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums, and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
18. This small group off-exchange product is not eligible for a premium tax credit.
19. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits.

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	Company officer signature	Printed name	Title	Date (MM/DD/YYYY)
	X			
Accepted by Anthem Blue Cross and Blue Shield and/or Anthem Life authorized representative		Printed name	Date (MM/DD/YYYY)	

Section G: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross and Blue Shield and/or Anthem Life to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield and/or Anthem Life reviews and approves the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield and/or Anthem Life.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem Blue Cross and Blue Shield and/or Anthem Life.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and Blue Shield and/or Anthem Life that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker		%	Second writing payable/sub-agent/producer/broker		%
Agency name		Agency ID no.	Agency name		Agency ID no.
Agent/producer/broker name			Agent/producer/broker name		
Agent/producer/broker ID no.			Agent/producer/broker ID no.		
Payable/sub-agent/producer/broker ID no. if different			Payable/sub-agent/producer/broker ID no. if different		
Street address			Street address		
City		State	City		State
		ZIP code			ZIP code
Phone no.		Fax no.	Phone no.		Fax no.
Email address			Email address		
Signature		Date (MM/DD/YYYY)	Signature		Date (MM/DD/YYYY)

For General Agent/Producer/Broker use only			
General agent/producer/broker name		Agent/producer/broker ID no.	
Street address		City	State
			ZIP code

Sales Representative and Account Manager			
Sales representative name		Sales representative ID no.	
Street address		City	State
			ZIP code
Account manager name		Account manager ID no.	

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)

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For 1-50 Employee Small Groups
Ohio**



Underwritten by Community Insurance Company



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