EMPLOYEE HEALTH ENROLLMENT APPLICATION

Group Size 2-14

Please complete in ink and return to your employer. Use extra sheets of paper if necessary.
Primary Care Physician (PCP) listings can be obtained through www.anthem.com.

APP

EMPLOYER/GROUP USE ONLY

Group Name		Group Number	Effective Date M D Y
Date of hire	Full time hire date	# Hours working per week	Date of eligibility for coverage

1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

❏ **Anthem Blue Cross and Blue Shield** ____________________

❏ **HealthKeepers, Inc.** ____________________ **(HMO)** ❏ **Priority Health Care, Inc.** ____________________ **(HMO)**

❏ **Peninsula Health Care, Inc.** ____________________ **(HMO)**

Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO or by Anthem Blue Cross and Blue Shield.

2. REASON FOR APPLICATION (Check as many as apply)

❏ Initial enrollment

❏ Annual open enrollment

❏ Add dependent

❏ New hire

❏ Rehire – Date of rehire:

❏ COBRA – Qualifying Event: ____________________

Event Date:

❏ Birth of child

❏ Adoption or placement for adoption (attach legal documentation)

Date of adoption/ date of placement for adoption:

❏ Marriage

Date of marriage:

❏ Loss of other coverage

Date previous coverage ended:

❏ Medical child support order (attach legal documentation)

Date of order:

❏ Appointment of Legal Guardian

Effective date of appointment:

❏ Other (please specify): ____________________

____

3. TYPE OF COVERAGE/PLAN

Health Coverage

❏ Employee Only ❏ Employee and One Child ❏ Employee and Family

❏ Employee and Spouse ❏ Employee and Children

4. EMPLOYEE INFORMATION* (Please refer to Definitions of Eligibility, Section 9)

**If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name and PCP number.*

Social security #	Date of birth (MM/DD/YYYY)	Sex: ❏ M ❏ F
Last name	First name	M.I.
Street address		Apt. #
City	State	Zip
Daytime phone (with area code) ( ) –	Evening phone (with area code) ( ) –	
Anthem PCP name* (please provide first and last name)		
Anthem PCP ID number*	Current patient? ❏Yes ❏No	

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
Anthem Blue Cross and Blue Shield and its affiliated HMOs, HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3

5. FAMILY INFORMATION* (If electing Employee Only coverage, skip to Section 6)

**If applying for HMO coverage , list the PCP name and PCP number. Each family member may select a different PCP.*

List all family members applying for coverage. List additional dependents on a separate sheet and attach it to the application. Please indicate the relationship between you and each dependent and provide the social security number and date of birth for each covered dependent. In the event of adding a newborn for which their social security number is not available, please complete this application at this time and forward to Anthem their social security number when obtained.

Relationship to applicant ❏Spouse ❏Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❏M ❏F

Last name | First name | M.I.

Check all that apply:

a. Child to be covered by non-custodial parent due to medical child support order? ❏Yes ❏No (if yes, attach documentation)

b. Disabled/ handicapped? ❏Yes ❏No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❏Yes ❏ No

Relationship to applicant ❏Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❏M ❏F

Last name | First name | M.I.

Check all that apply:

a. Child to be covered by non-custodial parent due to medical child support order? ❏Yes ❏No (if yes, attach documentation)

b. Disabled/ handicapped? ❏Yes ❏No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❏Yes ❏ No

Relationship to applicant ❏Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❏M ❏F

Last name | First name | M.I.

Check all that apply:

a. Child to be covered by non-custodial parent due to medical child support order? ❏Yes ❏No (if yes, attach documentation)

b. Disabled/ handicapped? ❏Yes ❏No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❏Yes ❏ No

Relationship to applicant ❏Child | Social security # – – | Date of birth (MM/DD/YYYY) | Sex: ❏M ❏F

Last name | First name | M.I.

Check all that apply:

a. Child to be covered by non-custodial parent due to medical child support order? ❏Yes ❏No (if yes, attach documentation)

b. Disabled/ handicapped? ❏Yes ❏No (if yes, attach physician certification)

PCP name* (please provide first and last name)

PCP ID number* | Current patient? ❏Yes ❏ No

6. TELL US ABOUT YOUR OTHER INSURANCE

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name

Policy/ID number

Effective date (MM/DD/YY)

Please indicate whom this coverage applies to (check all that apply):
❑Self ❑Spouse ❑All Children ❑Child: ______________________
Last Name First Name

Do you intend to continue this coverage? ❑Yes ❑No
If no, please provide cancellation date of coverage: ______________________
If yes, please provide the following information:

Address of other coverage

City

State

Zip

Phone number of other carrier/plan
( ) —

Policyholder name (Last, First, M.I.)

Policyholder's date of birth

Type of coverage:
❑Health ❑Dental

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A or B, complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person

First name

M.I.

HIC #

Medicare Part A Effective date

Medicare Part B Effective date

65 or over:
❑Working ❑Retired

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

8. EMPLOYEE STATEMENT (Please date and sign this statement and the employee certification on page 6 of this application.)

I certify that the information I have provided on this application is complete and true to the best of my knowledge and that all companies checked on page 1 will rely upon it in processing my application. I understand that each checked insurance company or HMO on page 1 of this application may deny claims and void my coverage if the company or HMO finds, within two years of the effective date of my coverage, that I misrepresented any of this information. I acknowledge that this certification pertains to all responses provided by me on this application and not just those that precede the certification.

I certify 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 under the policy.

The employee, and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature ______________________ Date ______________________

9. DEFINITIONS

Eligible employee:

- An active employee* of the Group Policyholder who works at least 25 hours per week and 50 weeks per year 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 Group Policyholder, provided that written approval of their eligibility is obtained from the HMO or Anthem Blue Cross and Blue Shield; or
- Employees eligible for continuous coverage under state or federal laws, e.g. COBRA.
- To become an eligible employee, a director or officer of a corporate Group must meet the same requirements as other employees of the Group Policyholder.
- Independent contractors (those whose wages are reported on IRS Form 1099) are considered to be self-employed and are not eligible for group coverage.

Eligible dependent:

- Employee's lawful spouse, or unmarried child who is under the age limit of the group's plan. Child includes a stepchild for whom the employee provides at least 50% support. It also includes any other child for whom the employee is legal guardian and for whom the employee provides at least 50% support.
- Dependents eligible for continuous coverage under state or federal laws, e.g. COBRA.

10. MEDICAL INFORMATION

Please note that no person will be denied health coverage on an individual basis due to the answers provided below.

❏ Employee

Social security #	Date of birth (MM/DD/YY)	Sex	Height (ft./in.)	Weight (lbs.)
_ _		❏ M ❏ F		

Last name	First name	M.I.

❏ Spouse

Social security #	Date of birth (MM/DD/YY)	Sex	Height (ft./in.)	Weight (lbs.)
_ _		❏ M ❏ F		

Last name	First name	M.I.

Please indicate the type of health coverage you are applying for:

❏ Employee Only ❏ Employee & Spouse ❏ Employee & One Child ❏ Employee & Children ❏ Employee & Family

1. Has any person to be covered by this plan had indications of, been diagnosed with, treated for or had treatment recommended for any of the following conditions? ❏ Yes ❏ No **If yes, place a check beside the condition.**

❏ Benign Tumor, **Location** __________
❏ Heart Attack
❏ Blood or circulatory problems
❏ Heart Disease, Angina
❏ Cancer, Type/**Location:** __________
❏ Liver Condition
❏ Connective Tissue Disease
❏ Stroke

2. Has any person to be covered by this plan had indications of, been diagnosed with, treated for or had treatment recommended for any of the following conditions within the past 5 years? ❏ Yes ❏ No **If yes, place a check beside the condition.**

❏ Alcohol or ❏ Drug Abuse/Addiction:
❏ Inpatient – Dates Treated __________ ❏ Outpatient – Dates Treated __________
❏ Arthritis or Rheumatism: Type __________ Degree of Severity __________
List medication used within the last 12 months __________
❏ Asthma or ❏ Other Respiratory conditions:
Frequency of attacks __________ Date of last attack __________
Dates of any hospitalizations __________ Dates of any ER visits __________
List medication used within the last 12 months and indicate how often taken __________

❏ Colitis or intestinal condition

❏ Diabetes: ❏ Diet ❏ Oral Medication or ❏ Insulin controlled

❏ Diseases of eyes, ears, nose or throat

❏ Disorder of spine and joints

❏ Elevated Cholesterol — List medication used within the last 12 months ______________________

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❏ Emotional or mental conditions: Diagnosis:

❏ Inpatient — Dates Treated ______________ ❏ Outpatient — Dates Treated ______________

List medication used within the last 12 months ______________________

Medication was prescribed by: ❏ Psychiatrist ❏ Family Physician

Date medication last used ______________________

❏ Epilepsy or Seizures: Type and date of last seizure ______________________

List medication used within the last 12 months ______________________

❏ Gall bladder disease or gall stones

❏ High blood pressure: Last reading and date ______________________

List medication used within the last 12 months ______________________

❏ Intervertebral Disc Disorders

Surgery? ❏Yes ❏No

Date of surgery ______________ Date of last symptom or treatment ______________

❏ Kidney disease or kidney stones

❏ Lung condition or tuberculosis

❏ Lupus: ❏ Systemic ❏ Discoid

❏ Muscle/nervous system disorder

❏ Paralysis

❏ Sleep Apnea

❏ Thyroid or goiter

❏ Ulcers or or other stomach condition

Surgery: ❏ Yes ❏ No

Type of Surgery ______________________ Date of surgery ______________________

3. Has any person to be covered by this plan been diagnosed with AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)? ❏ Yes ❏ No

4. Has any person to be covered by this plan been advised to have future medical treatment or surgery? ❏ Yes ❏ No

5. Has any person to be covered by this plan been examined or treated by a physician, psychotherapist, counselor, or other medical professional or taken any prescription drugs within the past 5 years for any illness or condition not already noted (excludes colds, flu and routine exams not related to a medical condition)? ❏ Yes ❏ No

6. If you answered yes to any of the questions above, please provide details in Section 11.

11. MEDICAL DETAILS (List additional information on a separate sheet and attach it to the application)

Question #	Name	Age	Specific Description of Illness	Duration Dates To From	Degree of Recovery*	Provider Name

*If not completely recovered, please indicate whether you are still under the care of a physician or other professional for the condition.

12. EMPLOYEE CERTIFICATION (Please date and sign this certification and the employee statement on page 3 of this application.)

I certify that I have read or have had read to me the completed application, and I realize that any false or misrepresentation in the application may result in loss of coverage under the policy. I certify that the information I have provided on this application is complete and true to the best of my knowledge and that the insurer or HMO will rely upon it in processing my application.

I understand that if false or misleading information is discovered within two years after the effective date of my coverage, the insurance company or HMO checked on page 1 of this application may void my coverage without advance notices and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by the insurance company or HMO exceeds the premiums paid, I agree to refund the excess amount to such insurance company or HMO.

The employee, and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature ______________________________ Date ____________________