

# Enrollment Application

## Group Size 51+ eligible employees



Anthem Health Plans of Kentucky, Inc.



Anthem Life Insurance Co.

### INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

#### SECTION 1: EMPLOYER/GROUP USE - Required

Employer name <b>Greg Neat Farm Gates inc</b>		Employer address <b>P O Box 82, Dunnville KY 42528</b>		
Group no. <b>63394</b>	Sub-group no./ Life division no.	Requested effective date	Life classification	Employee no./Dept. name

#### SECTION 2: REASON FOR APPLICATION - Required

<input type="checkbox"/> New enrollment	<input type="checkbox"/> COBRA	<input type="checkbox"/> New hire	<input type="checkbox"/> Add dependent (Fill in Section 3)
<input type="checkbox"/> Annual open enrollment (N/A to Life)	Qualifying event _____ event date _____	<input type="checkbox"/> Rehire date _____	
<input type="checkbox"/> Waiver (To decline ALL coverage skip to Section 12)			

#### SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date	<input type="checkbox"/> Marriage	<input type="checkbox"/> Adoption (Attach legal documentation)	<input type="checkbox"/> Loss of coverage (reason) _____	<input type="checkbox"/> Termed employment
	<input type="checkbox"/> Birth	<input type="checkbox"/> Legal guardianship (Attach legal documentation)	<input type="checkbox"/> Other _____	

#### SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical	Type of coverage
If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.	
<input type="checkbox"/> HMO <input type="checkbox"/> Anthem Essential <sup>SM</sup> PPO <input type="checkbox"/> Lumenos <sup>®</sup> HRA PPO <input type="checkbox"/> Lumenos <sup>®</sup> Health Incentive Account Plus PPO <input type="checkbox"/> POS <input type="checkbox"/> Blue Access <sup>®</sup> HSA <input type="checkbox"/> Lumenos <sup>®</sup> HIA PPO <input type="checkbox"/> Lumenos <sup>®</sup> Deductible First HRA PPO <input type="checkbox"/> PPO <input type="checkbox"/> Lumenos <sup>®</sup> HSA PPO*	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse (DP) <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage
If multiple Medical Plans are available, write plan number:	
*Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your Employer.	

Dental	Vision	Life
To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.		
<input type="checkbox"/> PPO _____ <input type="checkbox"/> Dental Blue <sup>®</sup> 100/200/300 <input type="checkbox"/> Dental Blue <sup>®</sup> 100	<b>Type of coverage</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	<b>Type of coverage</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+spouse (DP) <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage
		<input type="checkbox"/> Life (Fill in Section 7)

#### SECTION 5: EMPLOYEE INFORMATION - Required

Last name		First name		M.I.	Date of birth		Age	Social security no. (required)	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Height	Weight	Home phone		Business phone		Email address	
Address					City	State	ZIP code	County	
Retired <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation		Full-time hire date		Hours working per week	Income reported by <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other _____	

**SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.**

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner	Last name				First name				M.I.	Social security no. (required)			
	Date of birth		Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)					
	If spouse/DP address is different than employee, please provide full address												

Dependent	Last name				First name				M.I.	Social security no.				Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date of birth		Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)							
	Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)				If dependent address is different than employee, please provide full address										

Dependent	Last name				First name				M.I.	Social security no.				Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date of birth		Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Currently hospitalized or disabled <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)							
	Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)				If dependent address is different than employee, please provide full address										

**SECTION 7: LIFE AND DISABILITY INSURANCE - Required, if this type of coverage was selected in Section 4.**

Current Income \$ \_\_\_\_\_  Hour  Week  Month  Year  Life Class

Basic Life  Optional Life \_\_\_\_\_ x Annual Earnings  Basic AD&D  Short-Term Disability \_\_\_\_\_

Dependent Life OR \$ \_\_\_\_\_  Optional AD&D  Long-Term Disability \_\_\_\_\_

**Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.**

Short-Term Disability \_\_\_\_\_ %  Long-Term Disability \_\_\_\_\_ %  Basic Life

**Primary beneficiary**

Last name	First name	M.I.	Social security no.	Relationship to employee	Age
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**Contingent beneficiary**

Last name	First name	M.I.	Social security no.	Relationship to employee	Age
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**SECTION 8: OTHER HEALTH COVERAGE - Required**

Do you and/or your dependents have other health coverage?  Yes  No If yes, complete below.

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 no.	Effective date
Policy/certificate holder name		Social security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare?  Yes  No If yes, complete below.

Enrollee name	Medicare ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Medicare Part D ID no.		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)

**SECTION 9: PRIOR HEALTH COVERAGE - Required**Have you and/or your dependents had prior health coverage?  Yes  No If yes, complete below.Have you been covered by Anthem within the past two (2) years  
 Yes  No

Policy/certificate no.

Group name/ID no.

Date policy in effect

Date policy terminated

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years  Yes  No

List prior carrier(s)

Date policy in effect

Date policy terminated

Please check the type of prior coverage

 Employee Employee+Spouse/DP Employee+Child(ren) Employee+Spouse/DP+Child(ren)

Termination reason:

 Divorce/legal separation Employment terminated Employer/group contribution ceased Other Death of spouse/DP COBRA coverage exhausted Group plan terminated**SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.**

**Genetic Information Non-discrimination Act (GINA):** When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

**Health Savings Account Notice:** I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

- I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
- 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.
- 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.

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 have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. I represent that my answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my approval date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield.

**SECTION 11: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.**

**Read Section 10 carefully before signing.**

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature

X

Date

**SECTION 12: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.**

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
<input type="checkbox"/> Medical	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Dental	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Vision	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Life	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> All	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	

Check all that apply:

- I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) 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 certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. 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.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

- I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, 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 coverage in the future, I may be required to provide evidence of insurability at my expense.

**SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.**

Employee signature X	Date
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