

Enrollment Application



Anthem[®]Life

Group size 2-50 eligible employees

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. All information given should apply to this employer.

1. TYPE OF COVERAGE REQUESTED: Employee Only Employee+Spouse Employee+Child(ren) Family Life Only No coverage

2. ENROLLMENT INFORMATION Single Divorced Married

Relationship	Last Name, First Name, M.I.	Social Security No. Required	Sex	Age	Date of birth	Height/Weight	Current tobacco user?	Disabled?
Employee			<input type="checkbox"/> M <input type="checkbox"/> F			/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F			/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F			/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F			/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F			/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F			/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Home Address: Street, City, State, ZIP Code County

Employee Home Phone Employee Work Phone Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) Dependent Name(s)

3. MEDICAL INFORMATION (If yes, circle condition)

* Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.

1. Do you or your dependents regularly take medication? Yes No

2. Are you or any of your dependents currently pregnant? Yes No
If yes, name _____ due date _____

3. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor/growth; disorder of the blood or immune system; stroke, aneurysm, high blood pressure, diabetes (list age of onset below); mental/nervous disorder; Parkinson's disease; migraine/cluster headaches; seizures/epilepsy; depression; alcohol or drug abuse/dependency; kidney disease; kidney stones; liver or pancreas disorder; digestive/intestinal disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; muscular dystrophy; infertility/reproductive organ disorder; congenital disease or birth defect; cerebral palsy; or any other condition? Yes No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of Individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of Treatment	Hospitalized?	Surgery?	Recovered?
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

READ THE TERMS SECTIONS 4 AND 11 CAREFULLY BEFORE SIGNING. PLEASE REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant Signature Please Print Name Date

ANTHEM USE ONLY

Coordination of Benefits? Yes No Pre-ex (date)

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Name: _____

SS#: _____

5. PLEASE COMPLETE ALL INFORMATION						
Reason for application: <input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment (N/A for Life coverage) <input type="checkbox"/> Qualifying event (please complete date and reason) Event Date _____ <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption <input type="checkbox"/> Termed Employment <input type="checkbox"/> Other <input type="checkbox"/> COBRA Event _____ Date _____ <input type="checkbox"/> State Continuation <input type="checkbox"/> Waiver	Group Name	Group number	Sub Group Number	Group Address		
	Employee status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (please explain)	Hours working per Week _____ If not actively working, reason Projected Return Date	Occupation	Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other (please explain)		
6. COVERAGE SELECTION <i>(Availability dependent upon your employer's offering)</i>						
Medical Coverage Please check one type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	Check the medical plan you are applying for: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Anthem Essential SM PPO <input type="checkbox"/> Anthem Essential SM POS <input type="checkbox"/> Blue Preferred [®] Plus Hospital Surgical POS	<input type="checkbox"/> HDHP* <input type="checkbox"/> HDHP*/PPO <input type="checkbox"/> Core <input type="checkbox"/> Buy Up <input type="checkbox"/> PPO/PPO <input type="checkbox"/> Core <input type="checkbox"/> Buy Up	<input type="checkbox"/> Lumenos [®] Health Savings Account <input type="checkbox"/> Lumenos [®] Health Reimbursement Account <input type="checkbox"/> Lumenos [®] Health Incentive Account <input type="checkbox"/> Lumenos [®] Health Incentive Account Plus	*Do you have, or are you establishing a Health Savings Account? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Coverage: Please check one type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	Vision Coverage: Please check one type: <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
If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com .						
7. WAIVER OF COVERAGE SECTION: <i>(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)</i>						
NOTE: If waiving coverage, please complete this section. Section 4 must also be signed and dated.						
Medical Coverage declined for (check all that apply): <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) Dental Coverage declined for (check all that apply): <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) Vision Coverage declined for (check all that apply): <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) Life coverage declined for: <input type="checkbox"/> Myself For WI only: <input type="checkbox"/> I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP). <input type="checkbox"/> My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).						
8. PRIOR HEALTH INSURANCE INFORMATION						
Prior Health Care Coverage During the past 2 years (including Anthem):						
Insurance company name(s):	Type of prior coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Family <input type="checkbox"/> Other	Policy number	Effective Date	Cancel Date		
9. OTHER HEALTH INSURANCE INFORMATION						
On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date			
Policy/Certificate Holder's Name	Social Security Number	Date of birth	Relationship to applicant	Family members covered by Medicare:		
Medicare ID #	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#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date			

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Name: _____

SS#: _____

10. Life and Disability Insurance					
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Anthem By Design® Short Term Disability-BUY UP	Life Class	
<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Anthem By Design® Long Term Disability-BUY UP		
<input type="checkbox"/> Optional Life: _____ x annual earnings OR \$ _____			<input type="checkbox"/> Anthem By Design® Basic Life-BUY UP		
<input type="checkbox"/> Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			(Complete separate election form)		
<i>Primary Beneficiary</i>	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
<i>Contingent Beneficiary</i>	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age

11. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application in Section 4.

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: 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 Blue Cross Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

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| <ol style="list-style-type: none"> I may not assign any payment under my Anthem Blue Cross and Blue Shield program. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to enrollment. This exclusion may last up to 12 months from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a dependent that is enrolled in the plan prior to his/her 19th birthday. I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of prior creditable coverage from the prior Health Insurance Carrier. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my | <p>dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). 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 dependent(s) provided that I 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:</p> <ul style="list-style-type: none"> • Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or • My dependent or I become eligible for a subsidy (state premium assistance program) <p>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.</p> <ol style="list-style-type: none"> Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association. |
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In Wisconsin: Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWi") and Compcare Health Services Insurance Corporation ("Compcare"). Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies.

By signing Section 4, 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. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. **Thank you for choosing Anthem Blue Cross and Blue Shield.**

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.