

Employee Enrollment Application For 2-50 Employee Small Groups Virginia



And Its Affiliate HealthKeepers, Inc.

Health care plans offered by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. PPO health care plans are insurance products offered by Anthem Blue Cross and Blue Shield; HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc.

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.

Application completed for (check company that applies)

Anthem Blue Cross and Blue Shield

HealthKeepers, Inc.

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	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	Hire date (MM/DD/YYYY)	No. of hours worked per week	
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other – please specify: _____			
Section B: Application Type			
Select one			
<input type="checkbox"/> New enrollment	<input type="checkbox"/> COBRA –	Qualifying event date	
<input type="checkbox"/> Open enrollment	Select qualifying event	_____	
	<input type="checkbox"/> Left employment	<input type="checkbox"/> Reduction in hours	<input type="checkbox"/> Death
	<input type="checkbox"/> Loss of dependent child status	<input type="checkbox"/> Divorce or legal separation	
	<input type="checkbox"/> Medicare	<input type="checkbox"/> Covered employee's Medicare entitlement	

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

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield In Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO HealthKeepers, Inc. are independent licensees of the Blue Cross 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.

Section C: Type of Coverage**1. Medical Coverage**

Enter network, product and contract code selected:

Network – select one:

 KeyCare HealthKeepers HealthKeepers Open Access

Product

Contract code

Note for Lumenos Health Savings Account (HSA) enrollees:

If you enroll in an Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one: Employee only Employee + Spouse or Domestic Partner Employee + child(ren) Family**2. Dental Coverage** I am enrolling in my Employer's dental plan, if any.Member dental coverage – select one: Employee only Employee + Spouse or Domestic Partner Employee + child(ren) Family**3. Vision Coverage** I am enrolling in my Employer's vision plan, if any.Member vision coverage – select one: Employee only Employee + Spouse or Domestic Partner Employee + child(ren) Family

Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse's 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	
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 or Domestic Partner last name		First name		M.I.	Social Security no.* (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.* (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.* (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.* (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					

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Section E: Other Group Coverage

Are 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 No

On the day your coverage begins, will you or a family member be covered by other health coverage?

Yes No

If yes to either 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: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section F: Waiver/Declining Coverage**Medical Coverage**

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

Reason for declining coverage – check all that apply:

- Covered by spouse or domestic partner's group coverage
 Enrolled in other insurance –
 Please provide company name and plan: _____
 Enrolled in Individual coverage
 Spouse or domestic partner covered by employer's group medical Coverage
 Medicare/Medicaid/Tricare
 Other – please explain: _____
 No coverage

Dental Coverage

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

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes.

Vision Coverage

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

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further vision enrollment changes.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

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, domestic partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild, domestic partner's child, or any other child for whom the employee has legal guardianship or court-ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of intellectual disability or physical handicap 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. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

Section G: Terms, Conditions and Authorizations – Continued

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this application I represent that:

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.

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.

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, Anthem Blue Cross and Blue Shield or by another carrier.

Sign here	Applicant signature	Date (MM/DD/YYYY)
	X	

Special Enrollment Rights

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