

# Employee Change Form Application



Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections. Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing [www.anthem.com](http://www.anthem.com). Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through [www.anthem.com](http://www.anthem.com).

Employee Name		Last Name		First Name	
Group #	Division #	Request Date	Effective Date	Plan	Product
Health	Life	Medical	Life	Medical	Life
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Event date: \_\_\_/\_\_\_/\_\_\_

Address  
  Change Life Beneficiary  
  Cancel/Waiving Coverage (Refer to section 9)  
  PCP change  
  Name change  
 Change Life Classification  
  Enrollment in Medicare (see section 7)  
  Conversion  
  Benefit change  
  Cancel dependent  
  Other \_\_\_\_\_

Health Coverage	Dental Coverage	Vision Coverage	Life Coverage
<input type="checkbox"/> HMO*1 <input type="checkbox"/> POS* <input type="checkbox"/> PPO <input type="checkbox"/> Blue Traditional® <input type="checkbox"/> Anthem Essential <sup>SM</sup> PPO <input type="checkbox"/> Blue Priority <sup>SM</sup> *1 (Ohio only-a health insuring corporation product or "HIC") <input type="checkbox"/> Blue Access <sup>SM</sup> Hospital Surgical PPO <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 <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	<input type="checkbox"/> PPO <input type="checkbox"/> Traditional (Indiana and Ohio only) <input type="checkbox"/> Dental Blue® <input type="checkbox"/> Dental Blue® Choice 100 <input type="checkbox"/> Dental Blue® Choice 300 <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	<input type="checkbox"/> Vision <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	<input type="checkbox"/> Life (see section 6)

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

**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 WellPoint with information regarding my HSA. I hereby authorize the financial custodian to provide WellPoint with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide WellPoint with a written request to revoke my authorization at any time.

Last name		First name, M.I.		Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	Height	Weight
Home address				City	State	Zip code	County (KY residents include Municipality)		
Hours worked per week	Anthem PCP name and address*				Anthem PCP ID number*	New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

If PCP is a change, please indicate the reason for the change.

1 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name		First name, M.I.	
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other	Reason for change	
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)					
Anthem PCP name and address*			Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
2 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name		First name, M.I.	
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other	Reason for change	
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)					
Anthem PCP name and address*			Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
3 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name		First name, M.I.	
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Relationship to insured <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other	Reason for change	
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)					
Anthem PCP name and address*			Anthem PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

6. 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	Are you currently active at work?	
<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"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Optional Life: _____ x annual earnings OR \$ _____			<input type="checkbox"/> Anthem By Design Basic Life BUY-UP	If no, reason: _____	
<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
7. Other Health Coverage (Please check one: <input type="checkbox"/> Yes (complete below) <input type="checkbox"/> No)					
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 number	Effective date / /	
Policy/certificate holder's name		Social security number - -	Date of birth / /	Relationship to applicant	
If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.					
Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /	
		/ /	/ /	/ /	
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /		
Reason for Medicare entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD & Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)					
8. I agree to the Significant Terms, Conditions and Authorizations set forth in our application to join the Plan.					
<p>1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.</p> <p>2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.</p> <p>3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.</p> <p>4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions, (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)</p> <p>5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.</p> <p>6. Ohio: If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.</p> <p>7. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.</p> <p>8. THIS PARAGRAPH APPLIES ONLY TO MEMBERS OF OHIO GROUPS, AND DOES NOT APPLY TO MEMBERS OF INDIANA OR KENTUCKY GROUPS: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 &amp; 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.</p> <p>I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).</p> <p>Ohio: Any person who, with intent to defraud or knowing that he or she 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.</p> <p>Kentucky: 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.</p> <p>I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.</p>					
Applicant Signature				Date / /	