EMPLOYEE HEALTH ENROLLMENT APPLICATION

Group Size 2-14

Please PRINT 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	
Position/Title				

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

❑ **Anthem Blue Cross and Blue Shield**_____

❑ **HealthKeepers, Inc.**_____ **(HMO)**

Note for Lumenos Health Savings Account (HSA) enrollees:
If you enroll in an Anthem Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

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.

Limited Mandate HMO and PPO Plan Disclosures

In addition to offering health benefit plans that include all mandated benefits, Anthem Blue Cross and Blue Shield offers Limited Mandate PPO plans; and its affiliated HMO, HealthKeepers, Inc., offers Limited Mandate HMO plans.

The Limited Mandate HMO and PPO plans, which are now authorized by Virginia law, are not required to provide all state-mandated health benefits. These plans specifically exclude the following state mandated benefits: coverage for supplies and services related to cancer clinical trials for treatment studies on cancer, prescription contraceptives, hospitalization and anesthesia for dental procedures, diabetes education and training, early intervention, hemophilia, lymphedema except in the connection of breast reconstruction, mental health and substance abuse and TMJ. Obstetrical supplies and services are also excluded in Limited Mandate HMO and PPO plans offered in the 2-14 market only. **It is the group's responsibility to ensure it meets the federal requirement to have maternity coverage if it employs 15 or more employees.** Further, all Limited Mandate HMO and PPO plans include a $4000 per member per calendar year benefit maximum for medically necessary prosthetics and one glucometer per member per calendar year. Diabetic equipment and supplies are considered as durable medical equipment (DME) and as such are subject to the PPO $5000 and HMO $2000 DME annual benefit maximum.

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

❑ Initial enrollment
❑ Annual open enrollment
❑ New hire
❑ Rehire – Date of rehire: _____
❑ COBRA – Qualifying Event: _____
Event Date: _____
❑ Marriage
Date of marriage: _____
❑ Loss of eligibility for other coverage
Date previous coverage ended: _____
❑ Birth of child
❑ Add Dependent*
Date of adoption/placement for adoption, court order or legal appointment: _____

*If adding a dependent due to adoption, placement for adoption, medical child support order, legal appointment (such as guardianship), legal documentation must be attached to the enrollment application.

3. TYPE OF COVERAGE/PLAN

Health Coverage

❑ Employee Only
❑ Employee and Spouse
❑ Employee and One Child
❑ Employee and Children
❑ Employee and Family

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, PCP number and address.*

Social security #	Date of birth (MM/DD/YYYY)	Sex: ❑ M ❑ F
Last name	First name	M.I.
Street address (Please include 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*	
PCP Address	Current patient? ❑Yes ❑No	

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)			
Anthem PCP Name*	Anthem PCP ID #*		
Anthem PCP Address	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)			
Anthem PCP Name*	Anthem PCP ID #*		
Anthem PCP Address	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)			
Anthem PCP Name*	Anthem PCP ID #*		
Anthem PCP Address	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 ❑Group Insurance ❑Non Group Insurance

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A, B & D 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	Medicare Part D 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 Anthem Blue Cross and Blue Shield or HMO will rely upon it in processing my application. I understand that Anthem Blue Cross and Blue Shield may deny claims and void my coverage or HMO may cancel my coverage without advance notice if Anthem Blue Cross and Blue Shield 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.

For Lumenos 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.

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 step-child 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.
- For new and renewing groups, beginning on or after July 1, 2006, it also includes any other child of whom the employee has court ordered custody.
- 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

In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

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 (excluding high blood pressure)
❑ 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 _____

_____

❑ 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: 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

3. Has surgery been performed for any of the conditons listed in question 2? ❑ Yes ❑ No
   Type of surgery _____ Date of surgery _____

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

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

6. 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

7. 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.

(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 any false statement or misrepresentation in the application may result in loss of coverage under the policy.

- If the Company checked on page 1 of this application is Anthem Blue Cross and Blue Shield (Anthem), I understand that if false or misleading information is discovered within two years after the effective date of my coverage, Anthem may void my coverage without advance notice 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 Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.

- If the Company checked on page one of this application is HealthKeepers, Inc., Peninsula Health Care, Inc., or Priority Health Care, Inc., I understand that the health maintenance organization (HMO) may cancel my coverage without advance notice if it finds, within two years of the effective date of my coverage, that I misrepresented information on this application.

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 _____