

Enrollment Application
Group size 100+ eligible employees

Anthem 
**Anthem Health Plans
of Kentucky, Inc.**

Anthem Life 
**Anthem
Life Insurance Co.**

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com

1. Employer/Group Use: Employer Name and Address:		The KY Conference of the United Methodist Church						
Group #	Sub-group #/Life Division #	Request Effective Date	Life Classification	Applicant #/Dept. name				
		09 / 01 / 10						
Anthem use: Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)	
	/ /	/ /	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
2. Reason for Application				3. Status Change/Event				
<input checked="" type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment (N/A to Life) <input type="checkbox"/> COBRA Qualifying event _____				Event date ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Birth *Include legal documentation.				
<input type="checkbox"/> Waiver <input type="checkbox"/> New hire <input type="checkbox"/> Rehire (date) ___/___/___ <input type="checkbox"/> Add dependent (see section 3)				<input type="checkbox"/> Adoption* <input type="checkbox"/> Legal Guardianship* <input type="checkbox"/> Other _____				
4. Type of Coverage/Plan								
Health Coverage		Dental Coverage		Vision Coverage		Life Coverage		
<input type="checkbox"/> HMO* <input type="checkbox"/> POS* <input checked="" type="checkbox"/> PPO <input type="checkbox"/> Anthem Essential SM PPO <input type="checkbox"/> Blue Traditional [®] <input type="checkbox"/> Blue Access SM 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 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.		<input type="checkbox"/> PPO <input type="checkbox"/> Dental Blue [™] <input type="checkbox"/> Dental Blue [™] -100 <input type="checkbox"/> Dental Blue [™] -100/200/300 <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 7)		
5. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.								
Last name	First name, M.I.	Date of birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # (required)	<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)			
Home telephone		Business telephone		eMail Address				
Are you:	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: _____	
Anthem PCP name and address*					Anthem PCP ID number*		New patient?*	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Family Information *Spouse and dependents to be covered (Attach a separate sheet if necessary)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.								
* Please read the Genetic Information Non-discrimination Act (GINA) information on page 3, under Significant Terms, Conditions and Authorizations section, prior to answering the below questions.								
1 Last name		First name, M.I.		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)								
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # (required for spouse/domestic partner)	Height	Weight	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No	Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)	Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)	
Anthem PCP name and address*					Anthem PCP ID number*		New patient?*	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
2 Last name		First name, M.I.		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)								
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Height	Weight	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No	Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)	Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)	
Anthem PCP name and address*					Anthem PCP ID number*		New patient?*	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	

NAME _____ SSN _____

3 Last name		First name, M.I.		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)							
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Height	Weight	Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No	Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)	
Anthem PCP name and address*				Anthem PCP ID number*		New patient?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Life and Disability Insurance							
<input type="checkbox"/> Basic Life		<input type="checkbox"/> Basic AD&D		<input type="checkbox"/> Short Term Disability _____%		Life Class	
<input type="checkbox"/> Dependent Life		<input type="checkbox"/> Supplemental AD&D		<input type="checkbox"/> Long Term Disability _____%		Are you currently active at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Supplemental Life: _____ x annual earnings OR \$ _____		<input type="checkbox"/> Current Income: \$ _____		<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		If no, reason: _____	
<input type="checkbox"/> Anthem By Design* Short Term Disability-BUY UP		<input type="checkbox"/> Anthem By Design* Long Term Disability-BUY UP		<input type="checkbox"/> Anthem By Design* Basic Life-BUY UP (Complete separate election form)			
Primary Beneficiary	Last name	First name, M.I.		Social Security #	Relationship to applicant	Age	
Contingent Beneficiary	Last name	First name, M.I.		Social Security #	Relationship to applicant	Age	
8. Other Health Coverage Please check one: <input type="checkbox"/> YES (completed 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 88 / 88 / 88	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)							
9. Prior Health Coverage Please check one: <input type="checkbox"/> YES (completed below.) <input type="checkbox"/> NO							
Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No				Group name/ID#		Dates Policy in effect: / / - / /	
Policy/Certificate #:				List prior carrier(s)		Dates Policy in effect: / / - / /	
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please check the type of prior coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee / Spouse <input type="checkbox"/> Employee / Child(ren) <input type="checkbox"/> Employee / Spouse / Child(ren)							
Termination reason: <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of spouse <input type="checkbox"/> COBRA coverage exhausted <input type="checkbox"/> Employment terminated <input type="checkbox"/> Group plan terminated <input type="checkbox"/> Employer/group contribution ceased <input type="checkbox"/> Other:							

Significant Terms, Conditions and Authorizations (TERMS) Please read this section carefully before signing the application.

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.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
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.
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.
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.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.

6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

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).

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.

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.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

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

10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.	
By signing this, 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.	
Applicant Signature	Date / /
11. Waiver of coverage for employee and / or any eligible dependent not enrolling	
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply	
<input type="checkbox"/> I certify that 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. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.	
If I am declining enrollment for myself or my dependents (including my spouse) 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. 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:	
<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) 	
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.	
<input type="checkbox"/> I certify that 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. Neither my dependent(s) nor I were 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 such coverage in the future, I may be required to provide evidence of insurability at my expense.	
Applicant Signature	Date / /