Enrollment Application Instructions:

1. Please type your answers on the screen for the highlighted yellow areas.

2. When both page 2 and 3 are completed, print your application and sign on the front in the blue highlighted area.

3. Return both pages to your employer.

Any questions?
Call Forrest T. Jones & Company
800-821-7303 ext 1179

PRINT

Updated 1/2010

Enrollment Application

Anthem. Anthem Life

Group size 2-50 eligible employees

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.

Please complete 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	Full Time Student?	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F				/	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F				/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No			/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No			/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No			/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No			/	☐ Yes ☐ No	☐ Yes ☐ 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)***

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name _____ due date ____/____/____
4. 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? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ 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? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)

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 in sections 1 through 3 above and in sections 5 through 10 on page 2 and 3 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

Enrollment Application

Anthem | Anthem Life

Group size 2-50 eligible employees Name: _____ SSN: ___ ___ - ____

5. PLEASE COMPLETE ALL INFORMATION

Reason for application:
☑ New enrollment

Group Name

Group Address

Employee Hire/Rehire Date (Full time)

Employee status
☐ Active
☐ Disabled
☐ Retired
☐ Other (please explain)

Hours working per Week

If not actively working, reason

Projected Return Date

Occupation

Income reported by:
☐ W2
☐ 1099
☐ Other (please explain)

6. COVERAGE SELECTION *(Availability dependent upon your employer's offering)*

Medical Coverage
Please check one type:
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family
☐ 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: *(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)*

NOTE: If waiving coverage, please complete this section. Section 4 must also be signed and dated.

Medical Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)

Reason for Declining Coverage (check all that apply):
☐ Covered by spouse's group coverage - Carrier name and ID Number _____
☐ Enrolled in other Insurance provided by my employer
- Carrier name and ID Number _____
☐ Enrolled in Individual coverage - Carrier name and ID Number _____
☐ Spouse covered by employer's group medical Coverage
☐ Medicare
☐ Other (Please explain) _____
☐ No coverage

8. PRIOR HEALTH INSURANCE INFORMATION

Prior Health Care Coverage During the past 2 years (including Anthem):

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
	☐ Employee Only ☐ Employee + child(ren) ☐ Employee + spouse ☐ Family ☐ Other			

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? ☐ Yes ☐ 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)* ☐ Age ☐ Disability ☐ ESRD: Onset Date ____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date

Enrollment Application

Anthem. Anthem Life

Group size 2-50 eligible employees Name: _____ SSN: _____ _____ _____

10. Life and Disability Insurance

11. SIGNIFICANT TERMS, CONDITIONS AND (UNDERWRITES LIFE AND DISABILITY COVERAGES ONLY) AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 4.***

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company (underwrites life and disability coverages only) may accept certain persons or conditions for coverage. If accepted, my plan may exclude coverage for pre-existing conditions (Not applicable to MO HMO and Life insurance).
3. 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 (90 days in Kansas) prior to enrollment. This exclusion may last up to 12 months (90 days in Kansas) 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 child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption.
   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. (Not applicable to MO HMO products.)
4. 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 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:
   - 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.
5. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

Your health coverage will be provided by one of the following companies:

Anthem Blue Cross and Blue Shield is the trade name RightCHOICE Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). RIT, HMO Missouri, Inc., HALIC and ALIC are independent licensees of the Blue Cross and Blue Shield Association.

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.***