Employee Health Enrollment Application

Anthem

Anthem HealthKeepers

Please PRINT in ink and return to your employer.
Use extra sheets of paper if necessary.
The Primary Care Physician (PCP) listings of Anthem and its affiliated HMO, HealthKeepers, Inc. can be obtained through anthem.com or by calling 800-421-1880.

Effective date (MMDDYYYY)

EMPLOYER/GROUP USE ONLY

Group name			
Group number	Date of hire (MMDDYYYY)	Number of work hours per week	Eligibility date of coverage

1. SELECT ONE PLAN

☐ Anthem Blue Cross and Blue Shield plans:

- ☐ Plan 1 – PPO
- ☐ Plan 2 – PPO
- ☐ Plan 3 – PPO
- ☐ Plan 4 – PPO
- ☐ Plan 5 – PPO
- ☐ Plan 6 – PPO High Deductible
- ☐ Plan 7 – PPO High Deductible

☐ HealthKeepers, Inc. plans:

- ☐ Plan 8 – HMO High Deductible
- ☐ Plan 9 – HMO
- ☐ Plan 10 – HMO
- ☐ Plan 11 – HMO

2. REASON FOR APPLICATION (Check as many as apply and put the date on the space provided)

☐ Initial enrollment	☐ Annual open enrollment	☐ COBRA/Qualifying event	☐ COBRA/Event date (MMDDYYYY)
☐ Loss of other coverage (date ended)	☐ Marriage (date of marriage)	☐ Birth of child (date of birth)	☐ Add dependent*

*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

Health coverage:

- ☐ Employee only
- ☐ Employee and one child
- ☐ Employee and children
- ☐ Employee and Spouse
- ☐ Employee and Domestic Partner (if applicable for member college)
- ☐ Employee and family

4. EMPLOYEE INFORMATION *If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name and PCP ID number.

Social security number	Daytime phone number	Evening phone number	Sex ☐M ☐F	Date of birth (MMDDYYYY)	
Last name		First name			M.I.
Street address (please include apartment number)					
City			State	ZIP Code	
Primary Care Physician (PCP) name		PCP ID number	Are you a current patient of this PCP? ☐ Yes ☐ No		

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5. FAMILY INFORMATION (If electing Employee Only coverage, with no dependents, please go to Section 6)

***If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name and PCP ID 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 and forward the social security number to Anthem when it is obtained.

Relationship to applicant	Social security number	Sex	Date of birth (MMDDYYYY)
☐ Spouse ☐ Domestic Partner ☐ Child		☐ 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 before age 26? ☐ Yes ☐ No (if yes, attach physician certification)

Primary Care Physician (PCP) name	PCP ID number	Is the dependent a current patient of this PCP?
		☐ Yes ☐ No

Relationship to applicant	Social security number	Sex	Date of birth (MMDDYYYY)
☐ Child		☐ 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 before age 26? ☐ Yes ☐ No (if yes, attach physician certification)

Primary Care Physician (PCP) name	PCP ID number	Is the dependent a current patient of this PCP?
		☐ Yes ☐ No

Relationship to applicant	Social security number	Sex	Date of birth (MMDDYYYY)
☐ Child		☐ 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 before age 26? ☐ Yes ☐ No (if yes, attach physician certification)

Primary Care Physician (PCP) name	PCP ID number	Is the dependent a current patient of this PCP?
		☐ Yes ☐ No

Relationship to applicant	Social security number	Sex	Date of birth (MMDDYYYY)
☐ Child		☐ 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 before age 26? ☐ Yes ☐ No (if yes, attach physician certification)

Primary Care Physician (PCP) name	PCP ID number	Is the dependent a current patient of this PCP?
		☐ 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 12 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name	Policy/ID number

Please indicate whom coverage applies to	Name of person covered	Effective date (MMDDYYYY)
☐ Self ☐ Spouse ☐ Domestic Partner ☐ All children ☐ Child		

Do you intend to continue this coverage? ☐ Yes ☐ No
If no, please provide cancellation date of coverage _____
If yes, please provide the following information below:

Address of other coverage		
City	State	ZIP Code

Phone number of other carrier/plan	Type of coverage	Policyholder date of birth
	☐ Group Health Insurance ☐ Non-Group Health Insurance	

Policyholder last name	Policyholder first name	M.I.

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A, B and/or D complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person	First name of covered person	M.I.

HIC number	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date

Reason for medicare entitlement	65 or over
☐ Age ☐ Disability ☐ End stage renal disease (ESRD) ☐ ESRD and disability	☐ Working ☐ Retired

8. EMPLOYEE CERTIFICATION (Please date and sign this certification)

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 I elect to participate in the Council of Independent Colleges in Virginia Benefits Consortium, Inc. self-funded PPO plan or high deductible health plan, and check the corresponding box on page one of this application, I understand that if false or misleading information is discovered within two years after the effective date of my coverage, Council of Independent Colleges in Virginia Benefits Consortium, Inc. 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 Council of Independent Colleges in Virginia Benefits Consortium, Inc. exceeds the premiums paid, I agree to refund the excess amount to Council of Independent Colleges in Virginia Benefits Consortium, Inc.

If I elect to participate in a HealthKeepers, Inc. plan and check the corresponding box on page one of this application, I understand that the health maintenance organization (HMO) may cancel my coverage with 31 days advance written notice of termination 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 his/her request.

Employee signature	Date (MMDDYYYY)
X	

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