## Employee Health Enrollment Application





Please PRINT in ink and return to your employer.

Use extra sheets of paper if necessary.

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The Primary	y Care Physiciar	(PCP) listings o	f Anthem and its affiliated HMO, HealthKeepers, Inc.
			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 pla	ans:	HealthKeepers, Inc. plans:													
	PPO High Deductible PPO High Deductible	☐ Plan 8 — HMO High Deductible □ Plan 9 — HMO □ Plan 10 — HMO □ Plan 11 — HMO													
2. REASON FOR APPLICATION (Check as	s many as apply and put the date on	n 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*												
		d support order, legal appointment (su	uch as guardianship), legal documentation												
must be attached to the enrollment application.															
3. TYPE OF COVERAGE	ipiication.														
3. TYPE OF COVERAGE Health coverage: Employee only Employee and on Employee and chi		nestic Partner (if applicable for memb nily	-												
3. TYPE OF COVERAGE Health coverage: Employee only Employee and one	Employee and Sp c child Employee and Do Idren Employee and far ng for coverage that requires a Prim	nestic Partner (if applicable for memb nily	-												
3. TYPE OF COVERAGE Health coverage: Employee only Employee and ond Employee and chi 4. EMPLOYEE INFORMATION *If applying	Employee and Sp c child Employee and Do Idren Employee and far ng for coverage that requires a Prim	nestic Partner (if applicable for memb nily ary Care Physician (PCP), list the PCF	P name and PCP ID number. Date of birth (MMDDYYYY)												
3. TYPE OF COVERAGE Health coverage: Employee only Employee and ond Employee and chi 4. EMPLOYEE INFORMATION *If applying	Employee and Sp e child Employee and Do Idren Employee and far ng for coverage that requires a Prim Daytime phone number	nestic Partner (if applicable for memb nily ary Care Physician (PCP), list the PCF ivening phone number Sex	P name and PCP ID number. Date of birth (MMDDYYYY)												
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3. TYPE OF COVERAGE         Health coverage:       Employee only         Employee and one         Employee and chi         4. EMPLOYEE INFORMATION *If applyi         Social security number         Last name         Street address (please include apartmeter)	Employee and Sp e child Employee and Do ldren Employee and far ng for coverage that requires a Prim Daytime phone number E	nestic Partner (if applicable for memb nily a <b>ry Care Physician (PCP), list the PCF</b> ivening phone number Sex \[\[] M \[]	P name and PCP ID number. Date of birth (MMDDYYYY) F M.I.												
3. TYPE OF COVERAGE         Health coverage:       Employee only         Employee and one         Employee and chi         4. EMPLOYEE INFORMATION *If applyi         Social security number         Last name         Street address (please include apartmeter)	Employee and Sp e child Employee and Do ldren Employee and far ng for coverage that requires a Prim Daytime phone number E Daytime phone number F ent number)	mestic Partner (if applicable for memb nily ary Care Physician (PCP), list the PCF ivening phone number Sex M irst name	P name and PCP ID number. Date of birth (MMDDYYYY) F M.I.												

Page 1 of 4

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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 additionarelationship between you and each dependent and provide adding a newborn for which their social security number is Anthem when it is obtained.	the social secur	rity nu	mber	<sup>r</sup> and d	late of b	irth fo	or eac	h co	vered	depe	ender	nt. In	the e	vent	of		
Relationship to applicant	Social securit	y num	ber				Sex			Date	e of b	oirth (	(MMC	DYYY	Y)		
□ Spouse □ Domestic Partner □ Child		l i		I	I				F				I		I	I	
Last name			First	: name						I						M.I.	
Check all that apply: a. Child to be covered by non-custodial parent due to medic b. Disabled/ handicapped before age 26?						(if ye	s, att	ach (	locur	nenta	ition)	)					
Primary Care Physician (PCP) name		PCP	ID nu	mber			ie deµ ′es □		ent a	a current patient of this PCP?							
Relationship to applicant	Social securit	y num	ber				Sex			Date	e of t	oirth (	(MMD	DYYY	Y)		
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Check all that apply: a. Child to be covered by non-custodial parent due to medic b. Disabled/ handicapped before age 26? Yes No Primary Care Physician (PCP) name		physici	ian c			Is th		pendo				) atien1	t of tl	his PC	P?		
Relationship to applicant	Social securit	y num	ber				Sex			Date	e of b	oirth (	(MMD	DYYY	Y)		
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Last name			First	name												M.I.	
Check all that apply: a. Child to be covered by non-custodial parent due to medic b. Disabled/ handicapped before age 26? Yes No						(if ye	s, att	ach (	locur	nenta	ition)	)					
Primary Care Physician (PCP) name		PCP ID number				Is the dependent a				a current patient of this PCP?							
Relationship to applicant	Social securit	y num	ber				Sex			Date	e of t	oirth (	(MMD	MDDYYYY)			
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Last name			First	name												M.I.	
Check all that apply: a. Child to be covered by non-custodial parent due to medic b. Disabled/ handicapped before age 26? Yes No						(if ye	s, att	ach (	locur	nenta	ition)	)					
Primary Care Physician (PCP) name	PCP ID number					Is the dependent a current patient of this PCP? $\Box$ Yes $\Box$ No											

6. TE	<u>ell</u> u	I <u>s</u> ab	<u>OUT</u> \	/0UR	OTH	ER INS	SURA	NCE																						
	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.																													
Othe	Other carrier/plan name												Policy/ID number										I							
Please indicate whom coverage applies to Name of perso												<u>on c0</u>	verer	4			Ff		 	 	ן אחחי	/vv)								
Please indicate whom coverage applies to       Name of pe         Self       Spouse       Domestic Partner       All children       Child											heis	UII UU	VEIGU	1			L1	Effective date (MMDDYYYY)												
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:														_																
Addr	Address of other coverage														I															
City																								Sta	 nto	7IP	Code			
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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.													ate.																	
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