# Preferred Blue/Indemnity
# Member Enrollment/Member Change Form

Anthem

**PLEASE PRINT IN BLUE OR BLACK INK. SEE REVERSE SIDE FOR INSTRUCTIONS. NEW MEMBERS OF SMALL GROUPS MUST ALSO COMPLETE A STANDARDIZED HEALTH FORM.**

## 1. Tell Us About Yourself

Current Anthem Identification Number, if any

Subscriber's Social Security Number

Last Name | First Name | M.I.

Home Address Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone
( )

Please check one:
The applicant is ☐ Active Employee ☐ Retired Employee ☐ COBRA ☐ Other:_____

## 2. New Membership

☐ New Hire ☐ Open Enrollment
☐ New Group (initial enrollment) ☐ Life Event
☐ Rehire ☐ Waive Coverage (Go to Box 10)
☐ Retiree – date of retirement _____
☐ COBRA – start date _____
COBRA qualifying event: _____
☐ Other (reason) _____

## Anthem Use Only

| Issued Effective Date | Firm Division Number |
|---|---|
| ___/___/___ | |
| **Health Benefit Plan** | **Waiting Period** |
| | |

## 3. Change Membership

Date of Change or Event _____

**Type of Change:** ☐ Name Change ☐ Address Change ☐ Add Dependent ☐ Remove Dependent

**Reason for Change. Please check all that apply:**

☐ Marriage ☐ Birth ☐ Adoption ☐ Death
☐ Involuntary Loss of Coverage ☐ Involuntary Loss of Medicaid ☐ Covered by Medicaid ☐ Covered by Other Insurance
☐ Open Enrollment ☐ Entrance to the Military ☐ Discharge from the Military ☐ Divorce
☐ Court Order ☐ Voluntary Cancellation ☐ Other_____

## 4. Your Membership Choices

☐ Preferred Blue ☐ Indemnity
☐ HSA Health Plan ☐ Comprehensive HSA Health Plan
☐ PCA

**Type of Membership:** ☐ Single ☐ Couple ☐ Parent/Child(ren) ☐ Family

## 5. Where You Work

Company Name _____

Date of Hire ☐ Rehire ☐ ___/___/___ Date Eligible ___/___/___

**Firm Number/Health Benefit Plan**

(ex: 123456000 001)

## 6. List Members To Be Added/Cancelled

**If your Group Health Benefit Plan includes covering Domestic Partners, a completed affidavit of Domestic Partnership must be attached to this application. See reverse side for further instructions.**

| Sex | Names of Person(s) to be covered: Last Name | First Name | M.I. | Add | Remove | Birthdate |
|---|---|---|---|---|---|---|
| ☐ M ☐ F | Self | | | | | |
| ☐ M ☐ F | Legal Spouse ☐ or Domestic Partner (DP) ☐ | | | | | |
| ☐ M ☐ F | Dependent | | | | | |
| ☐ M ☐ F | Dependent | | | | | |
| ☐ M ☐ F | Dependent | | | | | |

**Note: If electing Dependent Coverage, please list all eligible children, and complete a Dependent Student Certification Form if dependent has reached the age of 19 and is attending an accredited school full time. If your child is disabled, incapable of self-support and over the age of 19 complete a Certification for a Mentally or Physically Incapacitated Dependent Child Form. This form must also be completed by your physician.**

## 7. Tell Us About Your Other Insurance

**Note: All questions must be answered before Enrollment/Member Change form can be processed.**

**A.** Will you or any other family member covered under this policy also have medical coverage from another health plan? (Including another Anthem or Blue Cross Blue Shield Plan)
☐ Yes ☐ No If yes, name and address of insurer _____

Name of insured _____ Date of birth _____ Policy # _____ Effective Date _____ ☐ Single ☐ Two Person ☐ Family

**B.** Will medical coverage you are now electing replace another health insurance? ☐ Yes ☐ No If yes, name and address of insurer _____

Group # _____ Policy # _____ Effective Date of Policy _____ End Date of Policy _____

**C.** Are all of your eligible dependents/spouse applying for coverage? ☐ Yes ☐ No If not, why _____

**D.** If you have listed a dependent that is not a stepchild and does not have your last name, please indicate why. _____

## 8. Other Information

**Is anyone listed on this application currently eligible for Medicare? ☐ Yes ☐ No** ***If yes, please complete the following for each person to be covered who has Medicare.***

| Name(s) of Medicare Beneficiaries | Health Insurance Claim Number | Medicare Part A Effective Date | Medicare Part B Effective Date | Medicare Part D Effective Date | Check all reasons you qualified for Medicare: Age 65 | Disability | ESRD |
|---|---|---|---|---|---|---|---|
| | | / / | / / | / / | | | |
| | | / / | / / | / / | | | |

## 9. Employee Signature

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete to the best of my knowledge and belief. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

_____ ___/___/___
Employee Signature Date

## 10. Election Not To Enroll

I do not wish to enroll in a plan. Please check one:

☐ I have other coverage. Employer offering coverage _____ Insurance Co _____

☐ I do not have any other coverage. I understand that the opportunity to enroll at any future date will be subject to any group requirements, Anthem policies and NH RSA 420-G:8.

_____ ___/___/___
Signature Date

# Welcome to Anthem Blue Cross and Blue Shield

Please follow the instructions below to complete your Enrollment Application. You must also complete and submit a Standardized Health Form if your Group Health Benefit Plan is offered through a small employer group (1-50 lives). Please check with your employer's Benefit Administrator for further information.

**Box 1: Tell Us About Yourself**
This is required information. The Current Anthem Identification Number should only be completed if you are changing, updating or terminating an existing policy. You will not have an Anthem ID Number if this is a new enrollment.

**Box 2: New Membership**
This is required information if you are a New Hire, Rehire, New Enrollee or COBRA participant.

**Box 3: Change Membership**
This is required information if you are an existing member changing your membership. New subscribers are not required to complete this information.

**Box 4: Your Membership Choices**
This information is mandatory for New Enrollment. It is optional for all other changes.

**Box 5: Where You Work**
The Company Name, the Firm Division Number and the Health Benefit Plan Number are mandatory when completing this application. The Date of Hire/Rehire is mandatory for New Members only.

**Box 6: List Members To Be Added/Cancelled**
This is required information for New Members, Dependent Removals/Additions, Date of Birth Changes/Updates, and Dependent Name Changes. It is not required for:
Address Changes or Terminating the Entire Policy.

**Note:** The Domestic Partner rider may be available to be purchased by your group, for some products, if certain criteria have been met. Please check with your Benefit Administrator to find out if your group offers this benefit and if domestic partner coverage is available for the product you have indicated, and to complete the required affidavit.

**Box 7 and 8: Tell Us About Your Other Insurance and Other Information**
This information is **required** when enrolling as a new member or when a member is added to your existing policy. Some products may not be available if you have other insurance. Check with your Benefit Administrator. Your application will be returned, if this information is not completed.

**Note:** Each year, Anthem Blue Cross and Blue Shield saves millions of dollars for our members and groups through Coordination of Benefits. Other insurance and/or Medicare information helps to ensure that you receive all the benefits to which you are entitled. By dividing health care expenses appropriately between your plans, we can better control health care costs.

**Box 9: Employee Signature**
You must sign your application for it to be valid. If you are a Benefit Administrator terminating a Subscriber, please sign your name in the space provided.

**Box 10: Election Not To Enroll**
Complete this box only if you are waiving coverage.

**Completed applications may be returned to Anthem Blue Cross and Blue Shield by one of two methods:**

**Mail:** Anthem Blue Cross and Blue Shield, 3000 Goffs Falls Road, Manchester, NH 03111-0001
**Fax:** (603) 665-5420