INSTRUCTIONS

Please print all information.

THANK YOU FOR CHOOSING OUR PLAN.

How to Fill Out This Form – Press Firmly – Please Use Ballpoint Pen

Please read these instructions before filling out the attached Enrollment and Membership Change Form. Here's what you need to fill out, so we can enroll you without delay.

For membership changes, complete:
Section 1. "Tell Us About You"
Section 3. "Change Membership"
In addition, when adding/cancelling eligible dependents, or changing a Primary Care Physician (PCP), complete:
Section 6. "List Family Members"

1. Tell Us About You

Please complete all information in this section.

2. New Membership

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a-538 extension of coverage member, please indicate the date of the Qualifying Event, and also the Reason Code.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT
PCP	LEGALLY SEPARATED	BIRTH
NAME	DIVORCED	ADOPTION

4. Your Membership Choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice(s). If you choose "BlueCare", "Dental", or "other", please be sure to write the name of the plan as instructed by your Benefits Coordinator.
B. Please check individual, two person or family for each plan choice.

5. Where You Work

Please complete all information in this section.

6. List Members To Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers, and the name(s) of recognized institution(s) for full time student dependent(s) age 19 or over.
B. Indicate last name if different.
C. If any dependent(s) listed are disabled, please circle that dependent, and attach the appropriate application which may be obtained from your Benefits Coordinator.

D. Special instructions for BlueCare. A Primary Care Physician (PCP) must be selected for each member. Each member may choose a different PCP. Specialists cannot be selected as PCPs. Please also write in the city or town where the PCP's office is located, and the PCP provider number, located in your Provider Directory.

An asterisk (*) next to a Physician's name in the provider listing means the physician can only be seen by a current patient. If you are a current patient and want that physician to be your PCP, please check the box next to the physician's name on the application.

E. If coverage is available through your employer's plan for domestic partnerships, please include the appropriate certification forms.

7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section.

8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare or Medicaid disability.

9. Employee Signature

Please sign and return the completed application to your employer's Benefits Coordinator. Save your copy of this form for your records until you receive your identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.

Anthem

Enrollment and Membership Change Form

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

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

City | State | Zip Code

Home Telephone ( )

Work Telephone ( )

MARITAL STATUS ☐ Single ☐ Married ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C.G.S. 38a-538
DATE OF QUALIFYING EVENT MM / DD / YR
REASON ____ SEE INSTRUCTION SHEET
☐ NEW GROUP (ORIG ENROLLMENT)

3. Change Membership

CHANGE:
☐ ADDRESS
☐ NAME
INDICATE FORMER NAME
☐ OTHER
REASON
DATE MM / DD / YR

To Be Completed By Employer

Requested Effective Date MM / DD / YR

Firm Division No.

Health Benefit Plan

For Office Use Only

4. Your Membership Choices

	Individual	Two Person	Family
☐ BLUECARE PLAN NAME	☐	☐	☐
☐ CENTURY PREFERRED/PPO	☐	☐	☐
☐ DENTAL PLAN NAME	☐	☐	☐
☐ HMO--NEW ENGLAND	☐	☐	☐
☐ Lumenos H.S.A.*	☐	☐	☐
☐ Lumenos H.R.A.	☐	☐	☐
☐ Lumenos H.I.A.	☐	☐	☐
☐ Lumenos H.I.A. Plus	☐	☐	☐
☐ OTHER PLAN NAME	☐	☐	☐

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? ☐ YES ☐ NO

5. Where You Work

COMPANY NAME

ARE YOU ACTIVELY AT WORK? ☐ YES ☐ NO / (IF NO) REASON ☐ SICK ☐ INJURED ☐ OTHER

ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? ☐ YES ☐ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? ☐ YES ☐ NO

DATE OF FULL TIME HIRE	DATE OF PART TIME HIRE	DATE OF REHIRE
MM / DD / YR	MM / DD / YR	MM / DD / YR

6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)	Full Time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or www.anthem.com) Check √ the box if you currently use this physician.
☐ M ☐ F	Self				/ /			Name PCP Provider No. ☐ City
☐ M ☐ F	Spouse				/ /			Name PCP Provider No. ☐ City
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.								
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage? ☐ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason For Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (Self)	Are you actively at work?	Retirement Date	Name (Dependent)	Is this person actively at work?	Retirement Date
	☐ YES ☐ NO	MM / DD / YR		☐ YES ☐ NO	MM / DD / YR

Medicare No.	Medicare A (Hospital) Effective Dates	Medicare B (Medical)	Medicare No.	Medicare A (Hospital) Effective Dates	Medicare B (Medical)
	MM / DD / YR	MM / DD / YR		MM / DD / YR	MM / DD / YR

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date MM / DD / YR

COPY 1 - ANTHEM BCBS