Enrollment Application
Group size 2-50 eligible employees

Anthem BlueCross BlueShield AnthemLife

Please complete in black or blue ink 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. 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.

Section 1: Type of coverage requested

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ Life only ☐ No coverage

Section 2: Enrollment information

☐ Single ☐ Married ☐ Divorced

Relationship	Last name, first name, M.I.	Social Security no. required*	Sex	Age	Date of birth (MM/DD/YY)	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
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No

Employee home street address	City	State	ZIP code	County

Employee home phone	Employee work phone	Employee email address

Dependent home street address – if different from employee	City	State	ZIP code	Dependent names

Section 3: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.

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 (excluding AIDS and HIV) 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: ___/___/_____ (MM/DD/YYYY)
4. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
5. In the last 5 years have you or any of your dependents been diagnosed or treated for any of the following? ☐ Yes ☐ No Check all that apply.

☐ Heart/circulatory condition ☐ Cancer/tumor ☐ Disorder of the blood or immune system (excluding AIDS and HIV)
☐ Stroke, aneurysm ☐ Diabetes **(list age of onset below)** ☐ Mental/nervous disorder ☐ Alcohol or drug abuse/dependency
☐ Depression ☐ Kidney, liver or pancreas disorder ☐ Ulcerative colitis ☐ Crohn's disease
☐ Lupus ☐ Lung disorder ☐ COPD ☐ Emphysema
☐ Arthritis ☐ Back/disk disorder ☐ Multiple sclerosis ☐ Muscular dystrophy
☐ Other condition: _____

Explain "Yes" answers to any question. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date	Date(s) of treatment	Hospitalized	Surgery	Recovered
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

*Anthem is required by the Internal Revenue Service to collect this information.

Section 4: Life and disability insurance

☐ Basic Life ☐ Dependent Life ☐ Optional Life: _____ x annual earnings OR $_____ ☐ Current income: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year	☐ Basic AD&D ☐ Optional AD&D	☐ Short Term Disability ☐ Long Term Disability	☐ Anthem by Design® Short Term Disability BUY-UP ☐ Anthem by Design® Long Term Disability BUY-UP ☐ Anthem by Design® Basic Life BUY-UP Complete separate election form.			Life class

	Last name	First name	M.I.	Social Security no.	Relationship to applicant	Age
Primary beneficiary						
Contingent beneficiary						

Section 5: Reason for application

☐ New enrollment ☐ Open enrollment (N/A for Life coverage) ☐ COBRA Event: _____ Date: _____ ☐ State Continuation ☐ Waiver	Qualifying event– please complete date and reason. Event date: _____ ☐ Marriage ☐ Divorce ☐ Birth of child ☐ Adoption ☐ Terminated employment ☐ Other: _____

Section 6: Group information

Group name KPM Ltd.			Group no. 00191262	Subgroup no.
Group street address 18661 Comstock Circle	City Middleburg Hts.		State OH	ZIP code 44130	Full-time hire/rehire date
Employee status ☑ Active ☐ Disabled ☐ Retired ☐ Other: _____	Hours working per week 40	Occupation	If not actively at work, reason	
Projected return date	Annual salary	Income reported by ☑ W-2 ☐ 1099 ☐ Other: _____		

Section 7: Coverage selection — Availability dependent upon your employer's offering

Medical coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Check the medical plan you are applying for:

☑ PPO ☐ Anthem Essential℠ PPO ☐ HMO (HIC in Ohio) ☐ POS (Ohio only)	☐ Traditional ☐ Blue Access® Hospital Surgical PPO ☐ HDHP	☐ HDHP/PPO ☐ Core ☐ Buy Up	☐ PPO/PPO ☐ Core ☐ Buy Up	☐ Lumenos® Health Savings Account* ☐ Lumenos® Health Reimbursement Account* ☐ Lumenos® Health Incentive Account* ☐ Lumenos® Health Incentive Account Plus*

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

Dental coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage – Select one: ☐ 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 anthem.com.

A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.

Section 8: Waiver of coverage — Must be completed if employee and/or dependents waive medical, vision, dental or life coverage. NOTE: If waiving coverage, please complete this section. Section 12 must also be signed and dated.

Medical coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s) **Dental** coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s) **Vision** coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s) **Life** coverage declined for: ☐ Myself	Reason for declining coverage – Check all that apply: ☐ Covered by spouse's group coverage Carrier name: _____ ID no.: _____ ☐ Enrolled in other Insurance provided by my employer Carrier name: _____ ID no.: _____ ☐ Enrolled in Individual coverage Carrier name: _____ ID no.: _____ ☐ Spouse covered by employer's group medical Coverage ☐ Medicare ☐ Other: _____ ☐ No coverage

Section 9: Prior health insurance information — Prior health care coverage during the past two years (including Anthem)

Insurance company name(s)	Policy no.	Effective date	Cancellation date

Type of prior coverage: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family

Section 10: 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		Policy no.		Effective date
Insurance company street address	City	State	ZIP code	Insurance company phone no.
Policy/certificate holder's name	Social Security no.	Date of birth		Relationship to applicant
Family members covered by Medicare				Medicare ID no.

Part A effective date	Part B effective date	Medicare eligibility reason – Check all that apply ☐ Age ☐ Disability ☐ ERSD – Onset date:		
Medicare Part D carrier		Medicare Part D ID no.	Part D effective date	Part D termination date

ANTHEM USE ONLY – Coordination of benefits? ☐ Yes ☐ No

Section 11: Significant Terms, Conditions and Authorizations (TERMS) please read this section carefully before signing the application in section 12.

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of myHealth Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross BlueShield with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

1. I may not assign any payment under my Community Insurance Company (Anthem) program unless required by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage).
3. 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 31days 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.
4. Ohio: If applying for HMO/HIC coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
5. Ohio: **3904.04 NOTICE OF INFORMATION PRACTICES:** I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem 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.

I certify each Social Security number listed on this application is correct.

Section 12: Signature required

By signing below, 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.

Applicant signature	Printed name	Date
X		

Thank you for choosing Anthem Blue Cross and Blue Shield.