

# Employee Change Form



## INSTRUCTIONS:

Please complete this form **ONLY** if you are making changes to your existing coverage. If you are **APPLYING** for coverage or **ADDING** a dependent(s), complete the Anthem "Enrollment Application" instead of this form.

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in blue or black ink and return to your employer. Please use extra sheets of paper if necessary. **NOTE:** Some changes may be made by accessing [www.anthem.com](http://www.anthem.com).

SECTION 1: EMPLOYER/GROUP USE - Required													
Employer name						Employer address							
Group no.		Sub-group no./ Life division no.			Requested effective date			Life classification		Employee no./Dept. name			
SECTION 2: REASON FOR CHANGE - Required. Please be sure to provide date of event.													
Event date		<input type="checkbox"/> Address		<input type="checkbox"/> Add dependent		<input type="checkbox"/> Change Life beneficiary		<input type="checkbox"/> Other _____					
		<input type="checkbox"/> Name change		<input type="checkbox"/> Cancel dependent		<input type="checkbox"/> Change Life classification		<input type="checkbox"/> Enrollment in Medicare (Fill in Section 7)					
		<input type="checkbox"/> Benefit change		<input type="checkbox"/> Conversion				<input type="checkbox"/> Waiving coverage (Fill in Section 10)					
SECTION 3: PLAN/TYPE OF COVERAGE													
<b>Medical</b>										<b>Type of coverage</b>			
If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.													
<input type="checkbox"/> HMO		<input type="checkbox"/> Anthem Essential <sup>SM</sup> PPO		<input type="checkbox"/> Lumenos <sup>®</sup> HRA PPO		<input type="checkbox"/> Lumenos <sup>®</sup> Health Incentive Account Plus PPO				<input type="checkbox"/> Employee only			
<input type="checkbox"/> POS		<input type="checkbox"/> Lumenos <sup>®</sup> HSA PPO*		<input type="checkbox"/> Lumenos <sup>®</sup> HIA PPO		<input type="checkbox"/> Lumenos <sup>®</sup> Deductible First HRA PPO				<input type="checkbox"/> Employee+spouse (DP)			
<input type="checkbox"/> PPO												<input type="checkbox"/> Employee+child(ren)	
If multiple Medical Plans are available, write plan number:										<input type="checkbox"/> Family coverage			
*Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your Employer.										<input type="checkbox"/> No coverage			
<b>Dental</b>					<b>Vision</b>					<b>Life</b>			
<input type="checkbox"/> Dental Blue <sup>®</sup> 100/200/300		<b>Type of coverage</b>			<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee+spouse (DP)			<input type="checkbox"/> Life (Fill in Section 6)			
<input type="checkbox"/> Dental Blue <sup>®</sup> 100		<input type="checkbox"/> Employee only		<input type="checkbox"/> Employee+spouse		<input type="checkbox"/> Employee+child(ren)		<input type="checkbox"/> Family coverage					
		<input type="checkbox"/> Employee+child(ren)		<input type="checkbox"/> Family coverage		<input type="checkbox"/> No coverage		<input type="checkbox"/> No coverage					
SECTION 4: EMPLOYEE INFORMATION - Required													
Last name			First name			M.I.	Date of birth		Age	Social security no. (required)			
Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Height	Weight	Home phone		Email address			Hours worked per week			
Address						City		State	ZIP code		County		
SECTION 5: FAMILY INFORMATION - Spouse and dependents to be changed/cancelled, attach a separate sheet if necessary.													
Please read the Genetic Information Non-discrimination Act (GINA) information in Section 8, Significant Terms, prior to answering the questions in Section 5.													
Spouse/Domestic Partner	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Reason for change										
	Last name			First name			M.I.	Social security no. (required)					
	Date of birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		If spouse/DP address is different than employee, provide full address							

**SECTION 5: FAMILY INFORMATION – CONTINUED. Spouse and dependents to be changed/cancelled, attach a separate sheet if necessary.**

Please read the Genetic Information Non-discrimination Act (GINA) information in Section 8, Significant Terms, prior to answering the questions in Section 5.

Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Reason for change			
	Last name		First name		M.I.	Social security no.
	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other _____	If dependent address is different than employee, provide full address		

Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Reason for change			
	Last name		First name		M.I.	Social security no.
	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee <input type="checkbox"/> Child <input type="checkbox"/> Other _____	If dependent address is different than employee, provide full address		

**SECTION 6: LIFE AND DISABILITY INSURANCE**

Current income \$ _____	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Currently actively at work <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, reason _____
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Supplemental Life _____ x annual earnings	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short-Term Disability _____
<input type="checkbox"/> Dependent Life	OR \$ _____	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long-Term Disability _____

**Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.**

<input type="checkbox"/> Short-Term Disability _____ %	<input type="checkbox"/> Long-Term Disability _____ %	<input type="checkbox"/> Basic Life
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**Primary beneficiary**

Last name	First name	M.I.	Social security no.	Relationship to employee	Age
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**Contingent beneficiary**

Last name	First name	M.I.	Social security no.	Relationship to employee	Age
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**SECTION 7: OTHER HEALTH COVERAGE**Do you and/or your dependents have other health coverage?  Yes  No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company		Policy/certificate no.	Effective date
Policy/certificate holder name	Social security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid?  Yes  No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Medicare Part D ID no.	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date	

Reason for Medicare entitlement:  Age  Disability  ESRD & Disability  End Stage Renal Disease (ESRD)**SECTION 8: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.**

**Genetic Information Non-discrimination Act (GINA):** When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

**Health Savings Account Notice:** I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

**SECTION 8: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.**

- I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
- I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
- I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
- I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline to this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
- I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
- By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

**SECTION 9: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.**

Read Section 8 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature

X

Date

**SECTION 10: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.**

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
<input type="checkbox"/> Medical	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Dental	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Vision	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Life	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> All	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.

Check all that apply:

- I have been given a chance to apply for Anthem Blue Cross and Blue Shield coverage, and after careful thought, I have decided not to take this offer. If I want to apply for coverage at a later date, I can, based on established methods. If I have decided not to take this offer of coverage for myself or my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents later, as long as I ask to sign up within 31 days after other coverage ends. If my dependent or I are late enrollees, we may be subject to pre-existing conditions restrictions or waiting periods set out in the group certificate. The pre-existing exclusion may not apply to dependents enrolled in the plan before their 19th birthday. Also, 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 dependents if I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may sign up under two more circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium aid program).

In these cases, I may be able to enroll myself and my dependents if I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

- I have been given a chance to apply for the group life benefits offered by my employer/group. The benefits have been explained to me. I and/or my dependent(s) have decided not to join. My dependent(s) or I were not pressured by my employer/group, agent or life carrier, to say no to this coverage, but instead we chose to say no of our own accord. I agree that if I want to ask for coverage in the future, I may be asked to give proof of insurability at my own cost.
- I am covered, or will be covered, under some other plan that is not sponsored by my employer. I am not covered under Health Insurance Risk Sharing Program (HIRSP).
- My dependents are covered, or will be covered, under some other plan that is not sponsored by my employer. My dependents are not signed up for coverage under Health Insurance Risk Sharing Program (HIRSP).
- Other: \_\_\_\_\_

**SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.**

Employee signature

X

Date

