Medical Insurance and Anthem® Life

ENROLLMENT APPLICATION

Group size 51+ eligible employees

PLEASE COMPLETE IN INK and return to Advantage RN. Use extra sheets of paper, if necessary. *All information given should apply to this employer.*
Anthem's Primary Car Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

SECTION 1. TO BE COMPLETED BY EMPLOYER/GROUP

Employer Name and Address
Advantage RN 8892 Beckett Road West Chester, OH 45069

Group #	Sub-Group # / Life Division #	Request Effective Date	Life Classification	Applicant # / Dept. Name
00089286		____/____/____		

Anthem Plan Use:	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre Ex (Date)
	____/____/____	____/____/____	____/____/____	____/____/____	❑ Yes ❑ No	❑ Yes ❑ No	____/____/____

SECTION 2. APPLICANT INFORMATION

Reason for Application: ❑ New Enrollment ❑ New Hire ❑ Rehire (date) ____/____/____

❑ Waiver ❑ Annual Open Enrollment (N/A to Life) ❑ Add dependent (see Status Change/Event below)

❑ COBRA: Qualifying event ________________ Event date ____/____/____

Status Change/Event: Event date ____/____/____ ❑ Marriage ❑ Birth ❑ Adoption* ❑ Legal Guardianship* (*Include legal documentation)

❑ Other________________________

Type of Coverage/Plan: **Health Coverage** ❑ Blue Access℠ Hospital Surgical PPO ❑ Lumens® Health Savings Account
❑ Employee only ❑ Employee + Spouse ❑ Employee + Children ❑ Family Coverage ❑ No Coverage

Life Coverage ❑ Life (see section 5)

SECTION 3. EMPLOYEE INFORMATION *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products

Last Name	First Name, M.I.	Date of Birth / /	Age	Sex ❑ M ❑ F	❑ Single ❑ Divorced ❑ Married

Social Security # (SS# required for Lumenos® Health Savings Account)	Height	Weight
Home Address	City	State ZIP Code
County (KY residents include Municipality)	Home telephone	Business telephone
Email Address		

Are you: Retired? ❑ Yes ❑ No Disabled? ❑ Yes ❑ No Hospitalized? ❑ Yes ❑ No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ❑ W2 ❑ 1099 ❑ Other ________

Anthem PCP name and address*	Anthem PCP ID number*	New Patient?* ❑ Yes ❑ No

SECTION 4. FAMILY INFORMATION Spouse and dependents to be covered (Attach a separate sheet if necessary.)

1. Last Name | First Name, M.I. | Relationship to applicant: ❑ Spouse ❑ Daughter ❑ Son ❑ Other____________ | Fulltime student? ❑ Yes ❑ No

Is dependent's address different than applicant's address? ❑ Yes ❑ No (If yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	
/ /	❑ M ❑ F				Eligible for federal income tax exemption? ❑ Yes ❑ No Court ordered health care coverage? ❑ Yes ❑ No (If yes, include legal documentation) Currently hospitalized or disabled? ❑ Yes ❑ No (If yes, give reason)

Anthem PCP name and address* | Anthem PCP ID number* | New Patient?* ❑ Yes ❑ No

2. Last Name | First Name, M.I. | Relationship to applicant: ❑ Spouse ❑ Daughter ❑ Son ❑ Other____________ | Fulltime student? ❑ Yes ❑ No

Is dependent's address different than applicant's address? ❑ Yes ❑ No (If yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	
/ /	❑ M ❑ F				Eligible for federal income tax exemption? ❑ Yes ❑ No Court ordered health care coverage? ❑ Yes ❑ No (If yes, include legal documentation) Currently hospitalized or disabled? ❑ Yes ❑ No (If yes, give reason)

Anthem PCP name and address* | Anthem PCP ID number* | New Patient?* ❑ Yes ❑ No

3. Last Name | First Name, M.I. | Relationship to applicant: ❑ Spouse ❑ Daughter ❑ Son ❑ Other____________ | Fulltime student? ❑ Yes ❑ No

Is dependent's address different than applicant's address? ❑ Yes ❑ No (If yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	
/ /	❑ M ❑ F				Eligible for federal income tax exemption? ❑ Yes ❑ No Court ordered health care coverage? ❑ Yes ❑ No (If yes, include legal documentation) Currently hospitalized or disabled? ❑ Yes ❑ No (If yes, give reason)

Anthem PCP name and address* | Anthem PCP ID number* | New Patient?* ❑ Yes ❑ No

SECTION 5. LIFE AND DISABILITY INSURANCE

☑ Basic Life ☑ Basic Accidental Death & Dismemberment (AD&D)

Primary Beneficiary:	Last Name	First Name	M.I.
	Social Security #	Relationship to applicant	Age
Contingent Beneficiary:	Last Name	First Name	M.I.
	Social Security #	Relationship to applicant	Age
Life Class:	Are you currently active at work? ❑ Yes ❑ No	If no, reason:	

SECTION 6. OTHER HEALTH COVERAGE

❑ Yes (Complete below) ❑ No

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 number	Effective date

Policy/certificate holder's name	Social Security Number	Date of birth	Relationship to applicant

If you and /or your dependents are enrolled in Medicare Part A or Medicaid, complete the following:

	Medicare/Medicaid ID#	Medicare Part A	Medicare Part B	ESRD onset date
Enrollee's name(s)		effective date / /	effective date / /	/ /
Enrollee's name(s)		effective date / /	effective date / /	/ /

Reason for Medicare entitlement:

❑ Age ❑ Disability ❑ ESRD & Disability ❑ End Stage Renal Disease (ESRD)

SECTION 7. PRIOR HEALTH COVERAGE

❑ Yes (Complete below) ❑ No

Have you been covered by Anthem within the past two (2) years? ❑ Yes ❑ No

Policy/Certificate #:	Group name/ID#	Dates policy in effect: / / - / /

Have you and/or your dependents had prior coverage with another carrier (s) within the past two (2) years? ❑ Yes ❑ No

List prior carrier(s):	Dates policy in effect: / / - / /

Please check the type of prior coverage:

❑ Employee ❑ Employee/Spouse ❑ Employee /Child (ren) ❑ Employee/Spouse/Child(ren)

Termination reason: ❑ Divorce/legal separation ❑ Death of spouse ❑ COBRA coverage exhausted ❑ Employment terminated
❑ Group plan terminated ❑ Employer/group contribution ceased ❑ Other:

SECTION 8. SIGNIFICANT TERMS, CONDITIONS and AUTHORIZATIONS (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, my exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. Ohio: If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
7. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversations between Anthem and myself.
8. THIS PARAGRAPH APPLIES ONLY TO MEMBERS OF OHIO GROUPS, AND DOES NOT APPLY TO MEMBERS OF INDIANA OR KENTUCKY GROUPS: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information my only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPPA Privacy Regulations (45 C.F.R. Parts 160 & 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 that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date my result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application my result in denial of benefits or rescission or cancellation of my coverages(s).

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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.
Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
In Kentucky: Anthem Clue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

SECTION 9. ACKNOWLEDGEMENT OF TERMS

Read the TERMS section above carefully before signing. Please review your application for errors or omissions.
By signing this, 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.

Applicant's Signature:______________________________ Date:______________

SECTION 10. WAIVER OF COVERAGE for employee and/or any eligible dependent not enrolling

Check all that apply. Waiving: ❑ Health ❑ Dental ❑ Vision ❑ Life ❑ All

Name of person waiving	Already protected by coverage of: ❑ Spouse ❑ Parent ❑ None
Employer Name	Carrier: ❑ Anthem (give certificate/policy #) ❑ Other carrier (give name, ID #)

Check all that apply. Waiving: ❑ Health ❑ Dental ❑ Vision ❑ Life ❑ All

Name of person waiving	Already protected by coverage of: ❑ Spouse ❑ Parent ❑ None
Employer Name	Carrier: ❑ Anthem (give certificate/policy #) ❑ Other carrier (give name, ID #)

Check all that apply. Waiving: ❑ Health ❑ Dental ❑ Vision ❑ Life ❑ All

Name of person waiving	Already protected by coverage of: ❑ Spouse ❑ Parent ❑ None
Employer Name	Carrier: ❑ Anthem (give certificate/policy #) ❑ Other carrier (give name, ID #)

Check all that apply:

❑ I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependable (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. 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 dependents provided that I request enrollment with 31 days after marriage, birth, adoption or placement of adoption.

❑ I certify that I have been given an opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Applicant's Signature:______________________________ Date:______________