

# PPO/Indemnity Member Enrollment/ Member Change Form



## Anthem Use Only

Member ID Number \_\_\_\_\_ Firm # \_\_\_\_\_ Effective Date \_\_\_\_\_

### PLEASE PRINT IN BLUE OR BLACK INK.

#### 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 \_\_\_\_\_

#### 2. New Membership

Rehire \_\_\_\_/\_\_\_\_/\_\_\_\_

Retiree - date of retirement \_\_\_\_/\_\_\_\_/\_\_\_\_

Open Enrollment

New Hire \_\_\_\_/\_\_\_\_/\_\_\_\_

COBRA start date \_\_\_\_/\_\_\_\_/\_\_\_\_

Waive Coverage (Go to Box 6)

New Group (initial enrollment)

COBRA qualifying event \_\_\_\_/\_\_\_\_/\_\_\_\_

Life Event \_\_\_\_/\_\_\_\_/\_\_\_\_

Other (reason) \_\_\_\_\_

#### 3. Change to Existing 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

Loss of Coverage

Open Enrollment

Military Entrance/Discharge

Covered by Medicaid

Other \_\_\_\_\_

Court Order

Voluntary Cancellation

Divorce

Domestic Partner

Civil Union

Death

#### 4. Your Membership Choices

Preferred Blue®

Lumenos® H.S.A.\*

Lumenos® H.I.A.

Other: \_\_\_\_\_

Indemnity

Lumenos® H.R.A

Lumenos® H.I.A. Plus

\*Confirm with your employer which HSA custodian was selected.

Type of Membership:  Single

Couple

Parent/Child(ren)

Family

#### 5. Employer Information

Company Name \_\_\_\_\_

Firm No./Health Benefit Plan (ex:654321 000 000) \_\_\_\_\_

Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Rehire \_\_\_\_/\_\_\_\_/\_\_\_\_

Eligible Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

#### 6. Election Not To Enroll

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

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.

I have other coverage.

Name of policyholder \_\_\_\_\_

Insurance Company \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**7. 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 enrollment form.

Add Remove	Names of Person(s) to be covered					
	Last Name	First Name	M.I.	Social Security No.	Sex	Birthdate
	Self				<input type="checkbox"/> M <input type="checkbox"/> F	
	Ex/Legal Spouse <input type="checkbox"/>	Domestic Partner (DP) <input type="checkbox"/>	Civil Union <input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F	
	Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	
	Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	
	Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	

**Note:** If electing Dependent Coverage, please list all eligible children/stepchildren and complete all required forms according to your employer's guidelines.

**8. Prior Coverage Information - This section must be completed.**

Have you or any other family member had health insurance coverage in the 63 days prior to your date of hire or the effective date of your new policy?

Yes  No **If yes, please complete the following:**

	Self	Ex/Spouse/Domestic Partner/Civil Union	Dependents		
			1	2	3
Name of Insurance Company					
Certificate (Policy) Number					
Date Coverage Began					
Date Coverage Ended or Is Coverage Still In Effect?					

**9. Medicare 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	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
	/ /	/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name	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
	/ /	/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. 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 \_\_\_\_\_

**Anthem Use Only**

**Notes:**

Initials \_\_\_\_\_ Date Processed \_\_\_\_\_

## Welcome to Anthem Blue Cross and Blue Shield

Please follow the instructions below to complete your Enrollment Application. Please check with your employer's Benefit Administrator for further information.

### Box 1: Tell Us About Yourself

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, COBRA participant or a Retiree.

### Box 3: Change to Existing Membership

This is required information if you are an existing member changing your membership status. 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.

Anthem Consumer-driven Plan Descriptions:

Anthem Lumenos H.S.A. = Lumenos Health Savings Account  
Anthem Lumenos H.I.A. = Lumenos Health Incentive Account  
Anthem Lumenos H.I.A. Plus = Lumenos Health Incentive Account Plus  
Anthem Lumenos H.R.A. = Lumenos Health Reimbursement Account

### Box 5: Employer Information

The Company Name, Firm Division Number and Health Benefit Plan Number are mandatory when completing this application. The Date of Hire/Rehire is mandatory for New Members Only.

### Box 6: Election Not To Enroll

Complete this box only if you are waiving coverage.

### Box 7: List Members to Be Added/Cancelled

This is required information for New Members, Dependent Removal/Additions, Primary Care Physician (PCP) Changes, Date of Birth Changes/Updates and Dependent Name Changes. It is not required for Address Changes or Terminating the Entire Policy.

### Box 8: Prior Coverage Information

This information is required when enrolling as a new member or when a member is added to your existing policy. Your application will be returned if this information is not completed.

### Box 9: Medicare Information

This information is required for any member on this policy who is over 65 years of age or eligible for Medicare.

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 10: Employee Signature

Employee must sign the application for it to be valid. If you are a Benefit Administrator terminating a Subscriber please sign your name in the space provided.

### 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