Employee Enrollment Application
Association Health Plan Coverage
Kentucky

Anthem Blue Cross and Blue Shield | AnthemLife

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Height	Weight	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner			

Employee email address

Employment status	Current tobacco user?	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired	☐ Yes ☐ No		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

- ☑ New enrollment
- ☐ Annual open enrollment (not applicable to life and disability)
- ☐ New hire
- ☐ Rehire – Rehire date: (MM/DD/YYYY)
- ☐ Marriage – Date of marriage: (MM/DD/YYYY)
- ☐ Birth of child
- ☐ Add dependent (Fill in section 4)
- ☐ Loss of eligibility for other coverage – Date previous coverage ended: (MM/DD/YYYY)
- ☐ COBRA – Select qualifying event
  - ☐ Left employment
  - ☐ Reduction in hours
  - ☐ Death
  - ☐ Medicare
  - ☐ Loss of dependent child status
  - ☐ Divorce or legal separation
  - ☐ Covered employee's Medicare entitlement

  Qualifying event date: (MM/DD/YYYY)
- ☐ Waiver (To decline ALL coverage skip to section 9.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Reset Form | Save and Print

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Association Health Plan Coverage options

☐ Anthem Essential (PPO)
☐ Blue Access (PPO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO HRA (with Copay)

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Complete Essential Choice ☐ Other: _____

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Life and disability coverage

If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment. . . . . $_____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse . . . . . $_____ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child. . . . . $_____ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income – For employer/Anthem use	Occupation	Life and disability class no.– For employer/Anthem use
$_____		

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Social Security no.* (required)

Life and disability coverage — Continued

Primary beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent beneficiary — If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature **X**	Spouse name	Date (MM/DD/YYYY)

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Social Security no.* (required)

Voluntary Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Voluntary Accident Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ **Voluntary Critical Illness Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: _____

☐ **Voluntary Hospital Indemnity Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO , when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? ☐ Yes ☐ No (Please note that if the response is No, such applicants are not eligible for coverage)

Voluntary Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

Primary beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Contingent beneficiary – If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address					Percentage to be paid to beneficiary

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

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Social Security no.* (required)

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.
Note: Domestic partner coverage is not available for life and disability plans.

Spouse/Domestic Partner last name			First name		M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No	
Relationship to applicant: ☐ Spouse ☐ Domestic Partner						
PCP name				PCP ID no.	Existing patient? ☐ Yes ☐ No	

Dependent last name			First name		M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No	
Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______						
PCP name				PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: ______						

Dependent last name			First name		M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No	
Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______						
PCP name				PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: ______						

Dependent last name			First name		M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Height	Weight	Disabled? ☐ Yes ☐ No	Current tobacco user? ☐ Yes ☐ No	
Relationship to applicant: ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______						
PCP name				PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: ______						

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Social Security no.* (required)

Section 5: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 7, prior to answering the below questions.

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No

2. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary (with the exception of AIDS/HIV)? ☐ Yes ☐ No

3. Are you, or any of your dependents, currently pregnant? ☐ Yes ☐ No
   If yes, name: _____ Due date: (MM/DD/YY)

4. In the last five years, have you or any of your dependents, been diagnosed with AIDS or HIV? ☐ Yes ☐ No

5. In the last five years, have you or any of your dependents, been diagnosed or treated for any of the following? ☐ Yes ☐ No
   If yes, check all that apply.

- ☐ Arthritis
- ☐ Back/neck disorder
- ☐ Blood/bleeding disorder
- ☐ Cancer/growth/tumor
- ☐ Congenital disease or birth defect
- ☐ Diabetes/thyroid/endocrine disorder
- ☐ Digestive/intestinal disorder
- ☐ Heart/circulatory disorder
  - ☐ Aneurysm
  - ☐ High blood pressure
  - ☐ Coronary artery disease/heart attack
- ☐ Immune disorder (other than HIV)
  - ☐ Lupus
- ☐ Infertility/reproductive organ disorder
- ☐ Kidney/bladder/urinary disorder
- ☐ Liver/pancreas disorder
- ☐ Mental/nervous disorder
  - ☐ Depression
  - ☐ Alcohol or substance abuse
- ☐ Muscular dystrophy
- ☐ Nervous system disorder
  - ☐ Cerebral palsy
  - ☐ Multiple sclerosis
  - ☐ Seizures/epilepsy
  - ☐ Migraines/cluster headaches
  - ☐ Parkinson's
  - ☐ Stroke
- ☐ Respiratory/lung disorder
  - ☐ Asthma
  - ☐ Bronchitis/COPD
  - ☐ Emphysema
- ☐ Transplants
- ☐ Other condition: _____

Explain "Yes" answers to any question in section 5. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date (MM/DD/YY)	Date(s) of treatment (MM/DD/YY)	Hospitalized	Surgery	Recovered
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Social Security no.* (required)

Section 6: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: ______________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: (MM/DD/YY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

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Section 7: 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 (Anthem) 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 at any time.

1. I understand that I may not assign any payment under my Anthem program unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. 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.
4. 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.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

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 or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. I represent that 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 approval date may cause a material change in coverage or premium rates. Any materially false statement or misrepresentation 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.

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

By signing this application, I understand that I will get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. After I enroll, I can change my communication preferences by calling Member Services or going to anthem.com. I can also call Member Services to request a free copy of specific materials by mail.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 8: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 7 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	Date (MM/DD/YYYY)
X	

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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Social Security no.* (required)

Section 9: Waiver/Declining coverage

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Vision coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life and disability coverage

***Life/AD&D** coverage declined for: ☐ Myself
Spouse and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse and dependents

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse and dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life coverage
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, 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.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223
Anthem Life Insurance Company: P.O. Box 105448, Atlanta, GA 30348-5448

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