

Managed Care Member Enrollment/ Member Change Form



Anthem Use Only

Member ID no. _____ Firm no. _____ Effective date _____

PLEASE PRINT IN BLUE OR BLACK INK.

1. Tell us about yourself

Current Anthem Identification no., if any _____ Subscriber's Social Security no. _____

Last name _____ First name _____ M.I. _____

Home address _____ Apt. no. _____

City _____ State _____ ZIP code _____

2. New membership

- | | | |
|---|--|---|
| <input type="checkbox"/> Rehire ____/____/____ | <input type="checkbox"/> Retiree - date of retirement ____/____/____ | <input type="checkbox"/> Open enrollment |
| <input type="checkbox"/> New hire ____/____/____ | <input type="checkbox"/> COBRA start date ____/____/____ | <input type="checkbox"/> Waive coverage (Go to Box 6) |
| <input type="checkbox"/> New Group (initial enrollment) | <input type="checkbox"/> COBRA qualifying event ____/____/____ | <input type="checkbox"/> Life event ____/____/____ |
| <input type="checkbox"/> Other (reason) _____ | | |

3. Change to existing membership

Date of change or event _____

Type of change: Name change Address change Add dependent Remove dependent PCP change

Reason for change. Please check all that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Birth | <input type="checkbox"/> Adoption | <input type="checkbox"/> Loss of coverage |
| <input type="checkbox"/> Open enrollment | <input type="checkbox"/> Military entrance/discharge | <input type="checkbox"/> Covered by medicaid | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Court order | <input type="checkbox"/> Voluntary cancellation | <input type="checkbox"/> Divorce | _____ |
| <input type="checkbox"/> Domestic partner | <input type="checkbox"/> Civil union | <input type="checkbox"/> Death | _____ |

4. Your membership choices

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> HMO | <input type="checkbox"/> Access Blue New England | <input type="checkbox"/> Blue Choice New England | <input type="checkbox"/> BlueChoice |
| <input type="checkbox"/> HMO Blue New England | | | |
| Type of membership: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> 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

*In order to be eligible for the highest level of benefits available through your coverage, you and your dependents must choose a Primary Care Provider from the Network Directory and write the provider's code number in the Primary Care Provider/PCP code box(es). Before selecting a provider designated as "Current Patients Only" in the directory, be sure to contact the provider's office to verify your status as a current patient.

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 | | | Sex | Birthdate | Primary Care Provider | | Current patient |
|---------------|---|------------|------|--|-----------|---|---------|---|
| | Last name | First name | M.I. | | | Each member must fill in PCP information. For current listing of valid PCP's go to anthem.com. | | |
| | Self | | | <input type="checkbox"/> M <input type="checkbox"/> F | | Name | PCP no. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | SSN | - | - | | | | | |
| | <input type="checkbox"/> Ex/Legal spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil union | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | SSN | - | - | | | | | |
| | Dependent | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | SSN | - | - | | | | | |
| | Dependent | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | SSN | - | - | | | | | |
| | Dependent | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | SSN | - | - | | | | | |

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) no. | | | | | |
| 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 No. | | |
| Medicare Part A Effective date / / | Medicare Part B Effective date / / | Medicare Part D Effective date / / | Check all reasons you qualified for Medicare | | | |
| | | | Age 65 <input type="checkbox"/> | Disability <input type="checkbox"/> | ESRD <input type="checkbox"/> | |
| Name | | | | Health Insurance Claim No. | | |
| Medicare Part A Effective date / / | Medicare Part B Effective date / / | Medicare Part D Effective date / / | Check all reasons you qualified for Medicare | | | |
| | | | Age 65 <input type="checkbox"/> | Disability <input type="checkbox"/> | ESRD <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 _____

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.

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