Employee Enrollment and Change Form

Specialty Products 2-50 Member Small Groups

Use this form if you are not applying for medical coverage

Group no.	Social Security or Member no.

For your convenience, this single form may be used for enrollment or changes in dental, vision, life and disability coverage(s). Please complete in ink, using all capital letters. To avoid any delays, please answer all questions completely, be sure to sign and date your application, and return to your employer. You have the option of detaching the Health Statement at the end of this application, and submitting that page to your employer in a sealed envelope.

SECTION 1: DENTAL COVERAGE — Please ask your employer which dental plans are available, and check your selection

- ☐ Dental PPO Option 1
- ☐ Dental PPO Option 1 w/ Ortho
- ☐ Dental PPO Option 2
- ☐ Dental PPO Option 3
- ☐ Dental PPO Option 3 w/ Ortho
- ☐ Dental PPO Option 4
- ☐ Dental PPO Plus Option 1
- ☐ Dental PPO Plus Option 1 w/ Ortho
- ☐ Dental PPO Plus Option 2
- ☐ Dental PPO Plus Option 3
- ☐ Dental PPO Plus Option 3 w/ Ortho
- ☐ Dental PPO Plus Option 4

SECTION 2: VISION COVERAGE — Please ask your employer which vision plans are available, and check your selection

☐ Blue View℠ OR ☐ Blue View Plus

SECTION 3: LIFE AND DISABILITY COVERAGE — Please ask your employer what coverage(s) are being offered, and check your selection(s)

- ☐ Life and AD&D
- ☐ Dependent Life
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Supplemental Life; please select one: ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

Beneficiary	Relationship	Social Security no.	Percentage
Primary beneficiary name	Relationship	Social Security no.	Percentage*
Primary beneficiary name	Relationship	Social Security no.	Percentage*
Contingent beneficiary name	Relationship	Social Security no.	Percentage**
Contingent beneficiary name	Relationship	Social Security no.	Percentage**

*If choosing multiple Primary beneficiaries total must add up to 100%
**If choosing multiple Contingent beneficiaries total must add up to 100%

Please use a separate sheet, if needed, to list additional beneficiaries.

SECTION 4: EMPLOYEE INFORMATION — Please provide us with information needed to process your request (must be completed by employee)

Reason for application:
☐ New enrollment ☐ Changing coverage ☐ Changing beneficiary ☐ Changing personal information
☐ COBRA: Qualifying event ____________ Effective date ____________

Last name	First name	M.I.	Social Security or Member no.

Mailing address for member correspondence, Apt. no.	Physical address for member correspondence, Apt. no.	Do you have a spouse?* ☐ Yes ☐ No	No. of dependents including spouse*

City	State	ZIP code	Spouse's* Social Security no.

Employer name	Home phone no.
Occupation/Job title	Business phone no.

Hire date	☐ Part time ☐ Full time	Salary (required) $	☐ Hourly ☐ Weekly	☐ Monthly ☐ Yearly	No. of hours worked per week	Email address

* The term Spouse includes Common-Law Spouse, and if your employer offers coverage for them, Domestic Partner or Designated Beneficiary.
To meet eligibility requirements, applicable Affidavits must be completed by you and submitted to us. These Affidavits may be obtained through your employer or by calling our customer service department.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc.
Life and disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Social Security or Member no.

SECTION 5: ENROLLMENT INFORMATION — Please give us necessary information to enroll you and your dependent(s)

Gender	Last name	First name	M.I.	Height	Weight	Birthdate (mm/dd/yy)	Disabled?	Check if applicable; see notes below for additional action.
☐ Male ☐ Female	Employee						☐ Yes ☐ No	
☐ Male ☐ Female	Spouse*						☐ Yes ☐ No	☐ Retaining last name ☐ Different last name[2]
☐ Son ☐ Daughter	Other dependent						☐ Yes ☐ No	☐ Over-age[3] ☐ Court-ordered[4]
☐ Son ☐ Daughter	Other dependent						☐ Yes ☐ No	☐ Over-age[3] ☐ Court-ordered[4]
☐ Son ☐ Daughter	Other dependent						☐ Yes ☐ No	☐ Over-age[3] ☐ Court-ordered[4]
☐ Son ☐ Daughter	Other dependent						☐ Yes ☐ No	☐ Over-age[3] ☐ Court-ordered[4]

Note: (additional information/attachments needed:)

[1] Attach Mentally/Physically Disabled Dependent Form

[2] Attach applicable relationship affidavit

[3] Initial the Over-age Dependent Affidavit in Section 6

[4] Attach copy of court documents

If any enrolling dependent(s) do not live at the address listed in Section 2 on page 1, please provide their address(es) on a separate piece of paper.

SECTION 6: DECLINATION — Complete this section only if you want to decline coverage(s) for yourself and/or any eligible dependent(s)

Type of Coverage	Declined for:		Please write in "A", "B", "C", etc. per the list below to identify reason for declining (proof of other coverage may be required).
Dental plan	☐ Self ☐ Spouse* ☐ Child(ren)		A Covered by another group plan; carrier and ID are: ______
Vision plan	☐ Self ☐ Spouse* ☐ Child(ren)		B Covered by individual policy; carrier and ID are: ______
Life	☐ Self ☐ Dependents		C Covered by military service insurance D Have no other insurance coverage and am not interested
Disability	☐ Self ☐ Dependents		F Other: ______

I UNDERSTAND THAT:

- If I decline health coverage for myself and/or my dependent(s) (including my spouse*) because of other group or individual health insurance coverage, I may in the future be able to enroll myself and/or my dependent(s) in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new 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 within 31 days after the marriage, birth, adoption or placement for adoption.
- I may be required to submit additional information upon request.
- If I decline life and/or disability coverage for any reason, my dependents and I may enroll in the future as late entrants only if we provide satisfactory proof of insurability.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application. The plan has been explained to me, and I decline to participate.

X ______________________________ ______________
Employee signature if declining coverage for self/dependent(s) Date

* The term Spouse includes Common-Law Spouse, and if your employer offers coverage for them, Domestic Partner or Designated Beneficiary.
To meet eligibility requirements, applicable Affidavits must be completed by you and submitted to us. These Affidavits may be obtained through your employer or by calling our customer service department.

Social Security or Member no.

SECTION 7: OTHER COVERAGE — Provide information if you or your dependent(s) have, or had in the past 90 days, any coverage other than the applied for coverage

Name of person covered	TYPE (check one)		COVERAGES (check as many as apply)		Name of carrier	STATUS (check one)		DATES (if applicable)	
	Individual	Group	Dental	Prescription		Have now and intend to keep	Had in last 90 days	Start (mm/dd/yy)	End (mm/dd/yy)

SECTION 8: OVER-AGE DEPENDENT AFFIDAVIT

By initialing below, I verify and attest that my dependent(s), including over-age dependents ages 19 through 24, is/are unmarried and financially dependent on me or, regardless of age, is/are financially or otherwise dependent on me due to mental and/or physical disability; or is/are dependent on me due to a court order and therefore is/are eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem Blue Cross and Blue Shield or HMO Colorado within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem Blue Cross and Blue Shield or HMO Colorado and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year until the maximum age limit has been reached, as specified by the certificate. I understand that Anthem Blue Cross and Blue Shield or HMO Colorado reserves the right to request, at any time, proof of over-age dependency. Initials ______________

SECTION 9: AUTHORIZATION — The following Authorization is to be signed by ALL EMPLOYEES applying for coverage

The following statement applies to fully insured groups in Colorado, with 50 employees or less: COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I hereby authorize that:

1. at the request of Anthem, any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem about health-related services and supplies provided to me, persons covered under my health coverage, or persons to be covered under my health coverage. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;
2. the Medical Review and Underwriting departments or agents of Anthem, upon receiving this information may use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement request, or a request for change in policy benefits;
3. unless previously revoked, this authorization is valid for 24 months from the date I signed it; and
4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

I hereby authorize my employer, until this authorization is revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.

I AM APPLYING FOR LIFE AND/OR DISABILITY COVERAGE: I understand that I am submitting this application to Anthem Life Insurance Company and that if one or more of the following circumstances apply, then the health history information on this application will be used by Anthem Life to determine whether or not life and/or disability insurance will be offered to me; 1) the date of this application is more than thirty-one (31) days after my eligibility date for coverage; 2) the amount of term life coverage I am applying for is more than the guaranteed issue limit; 3) I am applying for long term disability coverage and my employer has less than 6 enrolled employees. I understand that if I am not actively at work on the date my insurance would otherwise become effective, the insurance will not become effective until I return to active work.

Signature of Employee (if applying for life and/or disability coverage): X ______________________________

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back pages, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado and me.

Employee signature	Date	Spouse* signature (if applying for coverage)	Date
X		X	

* The term Spouse includes Common-Law Spouse, and if your employer offers coverage for them, Domestic Partner or Designated Beneficiary.
To meet eligibility requirements, applicable Affidavits must be completed by you and submitted to us. These Affidavits may be obtained through your employer or by calling our customer service department.

Social Security or Member no.

SECTION 10: EMPLOYEE AUTHORIZATION, NOTICE AND REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE

My signature on page 4 of this application acknowledges my agreement with the Authorization below.

I understand that Anthem Life Insurance Company (Anthem Life) may collect personal information about me from outside sources and that both personal and privileged information may be disclosed to outside parties without my authorization only if such disclosure is permitted by applicable federal and state law. I also understand that under applicable federal and state law, I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem Life.

For the purpose of evaluating my Health Statement for Anthem Life coverage, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me or my health or that of my family for whom this Health Statement is made or their health to give Anthem Life or its reinsurers any such information. I also authorize Anthem Life or its reinsurers to release any information regarding me or my health or that of my family for whom insurance application is made to the Medical Information Bureau Inc.; or other life insurance companies with which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand this information will be used by Anthem Life to determine eligibility for insurance. This information includes any record or knowledge about medical history, including information contained in such records relating to sensitive services such as mental health, psychiatric, substance abuse, reproductive health, and information about HIV virus or AIDS, sexually transmitted or other communicable diseases. This includes but is not limited to all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. This authorization, for purposes of processing this application, will be valid from the date signed for a period of 30 months, and a photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy. For the purposes of processing a claim under this coverage, this authorization is valid for the duration of the claim.

I certify that I have read, or have had read to me, the completed Health Statement and that I realize any false statement or misrepresentation in the Health Statement may result in loss of coverage under the policy.

EMPLOYEE REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE
Your signature on this application acknowledges your agreement with the following representations.

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract subject to change by my written notice to my employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages, if necessary, for the required premium for the coverage for which I have applied.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I am applying for the coverage selected on this application. If I select a coverage, or a 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.
5. I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provision 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 the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). A photocopy is as valid as the original.

I give this representation for and on behalf of myself and my eligible dependents, including my children and my spouse* if covered by the plan. I am acting as their agent and representative.

The employee and any person authorized to act on behalf of the employee, is entitled to receive a copy of this representation and will be provided a copy of this application upon their request.

IMPORTANT NOTICE
Information regarding your insurability will be treated as confidential. Anthem Life or its reinsurers may, however, make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is PO Box 105, Essex Station, Boston, MA 02112.

Anthem Life or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. You may want to keep a copy of this statement for your records.

* The term Spouse includes Common-Law Spouse, and if your employer offers coverage for them, Domestic Partner or Designated Beneficiary.
To meet eligibility requirements, applicable Affidavits must be completed by you and submitted to us. These Affidavits may be obtained through your employer or by calling our customer service department.

Social Security or Member no.

SECTION 11: MEDICAL INFORMATION — Please complete this section if applying for life and/or disability coverage

You are NOT required to share this information with your employer. You may, at your discretion, return this completed application in a sealed envelope. Please write your name on the outside of the envelope for easy identification.

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date which you should use when answering questions that request you to provide prior history for a period of time.

This health questionnaire must be updated to include any change in health status that occurs between the date of application and the effective date.

Are you, your spouse* or any dependent child(ren) currently pregnant or an expectant parent? ☐ Yes ☐ No		If "Yes," please indicate due date ⟶	Due date
Twins or other multiple(s) expected? ☐ Yes ☐ No	Complications? ☐ Yes ☐ No	C-Section expected? ☐ Yes ☐ No	
In the past 5 years, has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?			☐ Yes ☐ No
Has anyone named in this application used tobacco products during the past 12 months? If "Yes," please complete the following:			☐ Yes ☐ No
Name(s)	☐ Cigarettes ☐ Pipe/Cigars ☐ Chewing tobacco	Duration	Frequency
In the past 5 years, has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs?			☐ Yes ☐ No
In the past 5 years, has anyone named in this application sustained an injury as a result of an auto or work related accident?			☐ Yes ☐ No

Within the past 5 years, has anyone applying for coverage been counseled, or consulted or treated for any of the following:	
1. Heart disease or disorder, stroke, circulatory disorder, chest pain, high or low blood pressure, anemia or blood disorder, elevated cholesterol and or/triglyceride levels or any other circulatory system issue?	☐ Yes ☐ No
2. Ulcers, stomach disorder, liver/pancreas disorder, hernia, gallbladder disorder, rectal disorder, intestine disorder, esophageal disorder, hepatitis, colitis, Crohn's disease or any other digestive system issue?	☐ Yes ☐ No
3. Urinary tract/kidney/bladder disorder, prostate disorder, renal failure, menstrual disorder, genital disorder, sexual dysfunction, infertility, dialysis, sexually transmitted disease, pregnancy complications (e.g., premature birth, miscarriage, C-Section), breast disorder or other genitourinary system issue?	☐ Yes ☐ No
4. Connective tissue disorder, thyroid disorder, adrenal disorder, diabetes, enlargement of the lymph-nodes, lymph system disorder, pituitary disorder, any growth disorder or other endocrine system issue?	☐ Yes ☐ No
5. Allergy(ies), asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath, sleep apnea or other respiratory system issue?	☐ Yes ☐ No
6. Arthritis, fibromyalgia, back/neck disorder, joint /bone disorder, knee disorder, carpal tunnel, skin disorder, chronic fatigue syndrome or other musculoskeletal issue?	☐ Yes ☐ No
7. Brain disorder, aneurysm, paralysis, central nervous system disorder, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue?	☐ Yes ☐ No
8. Cancer, tumor, abnormal growth, cyst or carcinoma-in-situ?	☐ Yes ☐ No
9. Eye or ear disorder?	☐ Yes ☐ No
10. Attention deficit disorder, psychological disorder, suicide attempt, depression, anxiety, autism or other behavioral health issue or biologically based mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder)?	☐ Yes ☐ No
11. Organ or other type of transplant or implant (including breast implants), gastric bypass, physical deformity or defect including cleft lip or cleft palate, prosthetic device, congenital disorder, down's syndrome?	☐ Yes ☐ No
12. Within the last 5 years, has anyone named in this application to be covered by this coverage had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? *We are **NOT** seeking the results of HIV Antibody Test.*	☐ Yes ☐ No

* The term Spouse includes Common-Law Spouse, and if your employer offers coverage for them, Domestic Partner or Designated Beneficiary.
To meet eligibility requirements, applicable Affidavits must be completed by you and submitted to us. These Affidavits may be obtained through your employer or by calling our customer service department.

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(Attach additional pages as needed. Please print your name and sign and date the additional pages.)

Name of person	Date(s) of treatment	Question no.	Give full details for each question answered "Yes," state the condition, duration and degree of recovery. If accident or injury, also indicate if auto or work related.	Name and address of attending physician or other health care provider

If anyone named in this application is taking medication or was prescribed or recommended any medication during the period of time related to your answer (i.e., past 5 years or currently taking), please list all of those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below.

(Attach additional pages as needed and sign and date the additional pages.)

Name of person	Name, dosage and frequency of medication (include illness or health condition for which medication was prescribed)	Date(s) medication taken (indicate if ongoing)	Name and address of prescribing physician or licensed health care provider

SECTION 12: TERMS AND CONDITIONS

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).**

Signature of employee	Date signed
X	