# Employee Enrollment Application
## Association Health Plan Coverage
## Kentucky

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 (MMDDYYYY) | 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 (MMDDYYYY) | 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
☐ New hire
☐ Rehire — Rehire date: ________ (MMDDYYYY)
☐ Marriage — Date of marriage: ________ (MMDDYYYY)
☐ Birth of child
☐ Add dependent (Fill in section 4)
☐ Loss of eligibility for other coverage — Date previous coverage ended: ________ (MMDDYYYY)
☐ 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: ________ (MMDDYYYY)

☐ 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.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223.

Social Security no.* (required):

## Section 3: Type of coverage

### Medical coverage

**Association Health Plan Coverage options**

☐ Pathway EPO
☐ Pathway EPO HSA
☐ Anthem Link Virtual First Pathway EPO
☐ 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

### Group Accident, Critical Illness, and Hospital Indemnity Insurance

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

☐ **Group 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: ______________________

☐ **Group 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)

### Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation. Attach a separate sheet if necessary.

| Beneficiary type | Name of beneficiary | Percentage | Social Security no.* | Relationship to applicant | | Date of birth |
|---|---|---|---|---|---|---|
| ☐ Primary ☐ Contingent | | % | | | | |
| | Street address | City | | State | ZIP code | Phone no. |
| **Beneficiary type** | Name of beneficiary | Percentage | Social Security no.* | Relationship to applicant | | Date of birth |
| ☐ Primary ☐ Contingent | | % | | | | |
| | Street address | City | | State | ZIP code | Phone no. |
| **Beneficiary type** | Name of beneficiary | Percentage | Social Security no.* | Relationship to applicant | | Date of birth |
| ☐ Primary ☐ Contingent | | % | | | | |
| | Street address | City | | State | ZIP code | Phone no. |
| **Beneficiary type** | Name of beneficiary | Percentage | Social Security no.* | Relationship to applicant | | Date of birth |
| ☐ Primary ☐ Contingent | | % | | | | |
| | Street address | City | | State | ZIP code | Phone no. |

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

*Anthem is required by the Internal Revenue Service to collect this information.

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.

| **Spouse/Domestic Partner** last name | First name | M.I. | Social Security no.* (required) |
|---|---|---|---|
| | | | |

| Sex | Birthdate (MMDDYYYY) | Height | Weight | Disabled | Current tobacco user? |
|---|---|---|---|---|---|
| ☐ Male ☐ Female | | | | ☐ Yes ☐ No | ☐ 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 | Birthdate (MMDDYYYY) | Height | Weight | Disabled | Current tobacco user? |
|---|---|---|---|---|---|
| ☐ Male ☐ Female | | | | ☐ Yes ☐ No | ☐ 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 | Birthdate (MMDDYYYY) | Height | Weight | Disabled | Current tobacco user? |
|---|---|---|---|---|---|
| ☐ Male ☐ Female | | | | ☐ Yes ☐ No | ☐ 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 | Birthdate (MMDDYYYY) | Height | Weight | Disabled | Current tobacco user? |
|---|---|---|---|---|---|
| ☐ Male ☐ Female | | | | ☐ Yes ☐ No | ☐ 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: ____________________

*Anthem is required by the Internal Revenue Service to collect this information.

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: ______ (MMDDYY)
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
  - ☐ Migraines/cluster headaches
  - ☐ Multiple sclerosis
  - ☐ Parkinson's
  - ☐ Seizures/epilepsy
  - ☐ 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 (MMDDYY) | Date(s) of treatment (MMDDYY) | 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 (MMDDYYYY) | Part B effective date (MMDDYYYY) | Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: (MMDDYY) |
|---|---|---|---|
| | | | |

| Medicare Part D ID no. | Medicare Part D carrier | Part D effective date (MMDDYYYY) |
|---|---|---|
| | | |

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) (MMDDYY) |
|---|---|---|---|---|---|---|---|
| | ☐ 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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Social Security no.* (required):

## 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 (MMDDYYYY) |
| --- | --- |
| 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

### Sign here only if you are declining coverage.

| Signature of applicant | Printed name | Social Security no. | Date (MMDDYYYY) |
|---|---|---|---|
| X | | | |

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223

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