PPO Employee Enrollment Application/Change/Waiver Form

EmployeeElect for 2-50 Employee Small Groups in Nevada

Anthem BlueCross BlueShield

For your convenience, this single form may be used for enrollment or changes in health, dental, vision, life and disability coverage(s). Please complete in black ink/type using all capital letters. To avoid any delays please answer all questions completely, sign and date your application, and return it 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.

Group no.

Social Security or member no.

1. EMPLOYEE INFORMATION – Please provide the following enrollment information (must be completed by the employee)

Reason for completing application:

☐ New enrollment ☐ Change of coverage ☐ Waiving coverage ☐ Terminating coverage ☐ Changing personal information
☐ COBRA/STATE Continuation qualifying event: _____ Effective date: ____/____/____ ☐ Other: _____
☐ Other qualifying event: _____ Date of qualifying event: ____/____/____

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

Mailing address for member correspondence *(PO Box not acceptable unless rural PO Box)* Apt no.	Marital status ☐ Single ☐ Married ☐ DP[1]	Spouse/DP Social Security or member no.

City	State	ZIP code	No. of dependents including spouse/DP (if none, indicate "0")	Home phone no.

Employer name	Occupation/Job title	Business phone no.

Hire date	No. of hours worked per week	Salary *(required if taking Life Insurance)* $ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly	Email address

2a. HEALTH COVERAGE – Please ask your employer which Medical options are available before checking your selection

PPO: AFFORDABLE COVERAGE
☐ PPO $40 GenRx/$1500
☐ PPO $30 GenRx/$1000
☐ PPO $25 GenRx/$500

PPO: SMART CHOICES*
☐ PPO $30/$1500 +
☐ PPO $30/$1000 +
☐ PPO $25/$500 +

*SMART CHOICE options have a separate pharmacy deductible for some prescriptions

PPO: BALANCED COSTS
☐ PPO $30/$4000
☐ PPO $30/$2000
☐ PPO $30/$1500
☐ PPO $30/$3000
☐ PPO $30/$1000

PPO: TOP OF THE LINE
☐ PPO $25/$500
☐ PPO $20 /$250
☐ Premier PPO $25

NEVADA - MANDATED PLANS
☐ PPO Basic
☐ PPO Standard

LUMENOS: CONSUMER DRIVEN
☐ HSA $5000/100** ☐ HRA $40/$4000
☐ HSA $3000/80** ☐ HRA $3000/70
☐ HSA $3000/100** ☐ HRA $25/$2500
☐ HSA $2500/80**
☐ HSA $2500/100**

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

OTHER
☐ _____ ☐ _____ ☐ _____

2b. DENTAL COVERAGE – Please ask your employer which Dental options are available before checking your selection

☐ Anthem Blue Dental PPO Option 1
☐ Anthem Blue Dental PPO Option 1 with ortho
☐ Anthem Blue Dental PPO Option 2
☐ Anthem Blue Dental PPO Option 3
☐ Anthem Blue Dental PPO Option 3 with ortho
☐ Anthem Blue Dental PPO Option 4

☐ Anthem Blue Dental PPO Plus Option 1
☐ Anthem Blue Dental PPO Plus Option 1 with ortho
☐ Anthem Blue Dental PPO Plus Option 2
☐ Anthem Blue Dental PPO Plus Option 3
☐ Anthem Blue Dental PPO Plus Option 3 with ortho
☐ Anthem Blue Dental PPO Plus Option 4

Other

2c. VISION COVERAGE – Please ask your employer which Vision options are available before checking your selection

☐ Blue View OR ☐ Blue View Plus

2d. LIFE AND DISABILITY COVERAGE – Please ask your employer which Life and Disability options are available before checking your selection

☐ 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

Primary beneficiary - *Last name*	*First*	*M.I.*	Relationship	Spouse/DP Social Security or member no.

Contingent beneficiary - *Last name*	*First*	*M.I.*	Relationship	Spouse/DP Social Security or member no.

[1] A person named as Domestic Partner (DP) under a Certificate of Registered Domestic Partnership. Ask your employer if coverage for domestic partner is offered under your selected plan. Include domestic partner information only if coverage for domestic partner is offered by your employer.

Social Security or member no.

3. ENROLLMENT INFORMATION – Please tell us about yourself and your eligible enrolling dependent(s)

FAMILY ADDITION: Date of marriage: Date of adoption: Date of Certificate of Registered Domestic Partnership:

Gender/ Relationship	Last Name	First Name	M.I.	Social Security No.	Height	Weight	Birthdate	Disabled	Check if applicable. See footnotes below for additional action
Employee ☐ Male ☐ Female	Employee							☐ Yes ☐ No	
Spouse/DP ☐ Male ☐ Female	Spouse/DP							☐ Yes ☐ No	☐ Retaining last name
☐ Son ☐ Daughter	Other Dependent							☐ Yes ☐ No	☐ Over-age[1] ☐ Court-Ordered[2]
☐ Son ☐ Daughter	Other Dependent							☐ Yes ☐ No	☐ Over-age[1] ☐ Court-Ordered[2]
☐ Son ☐ Daughter	Other Dependent							☐ Yes ☐ No	☐ Over-age[1] ☐ Court-Ordered[2]
☐ Son ☐ Daughter	Other Dependent							☐ Yes ☐ No	☐ Over-age[1] ☐ Court-Ordered[2]
☐ Grandson[3] ☐ Granddaughter[3]	Other Dependent							☐ Yes ☐ No	☐ Over-age[1] ☐ Court-Ordered[2]

[1] Initial the Over-age Dependent Affidavit section 4 below.
[2] Attach Court Order for court-ordered health coverage.
[3] Grandchild must be a court-ordered dependent.

Note: Any enrolling dependent(s) who do not live at the address listed in Section 1 on previous page, please provide their address(es) on a separate piece of paper.

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 and/or Anthem Life and my employer.

Signature of employee
X

Date

4. OVER-AGE DEPENDENT AFFIDAVIT

I verify and attest that my dependent(s) age 26 and over is/are unmarried and financially or otherwise dependent on me due to mental and/or physical disability and therefore 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 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(s) do(es) not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem Blue Cross and Blue Shield and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year as specified by the certificate. I understand that Anthem Blue Cross and Blue Shield reserves the right to request, at any time, proof of over-age dependency. *Initials:*

5. DECLINATION – Please complete if you want to decline coverage for yourself and/or any eligible dependents

Type of coverage:	Declined for:	Please select the box below identifying the reason for declining (proof of other coverage may be required).
Health plan	☐ Self ☐ Child(ren) ☐ Spouse/DP ☐ Grandchild(ren)	☐ Covered by another group plan; carrier and ID are: _____
Dental plan (if offered)	☐ Self ☐ Child(ren) ☐ Spouse/DP ☐ Grandchild(ren)	☐ Covered by individual policy, medicare or military coverage; carrier and ID are: _____
Vision plan (if offered)	☐ Self ☐ Child(ren) ☐ Spouse/DP ☐ Grandchild(ren)	☐ Have no other insurance coverage and am not interested.
Life/Disability (if offered)	☐ Self ☐ Dependents ☐ Spouse/DP Not available if employee declined life	☐ Other: _____

I ACKNOWLEDGE THAT:

- I decline coverage under a PPO policy and have no other group or individual health coverage at this time, my dependent(s) and I may enroll as a late entrant(s), only upon the employers annual renewal subject to a 6-month pre-existing waiting period.
- If I decline coverage for myself and/or my dependent(s) (including my spouse/domestic partner) because of other group or individual health insurance coverage except coverage under a state child health insurance program or a state Medicaid plan, 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 new dependent(s) as a result of marriage/registered domestic partnership, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s), provided that I request enrollment within 31 days after the marriage/registered domestic partnership, birth, adoption or placement for adoption.
- I may be required to submit additional information upon request.
- If I decline health coverage for myself or my dependents (including my spouse/domestic partner) because of coverage under a state child health insurance program or a state Medicaid plan, I may in the future be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility under the state child health insurance program or state Medicaid plan, provided that I request enrollment within 60 days: (1) after the date the coverage under a state child health insurance program or a state Medicaid plan ends; or (2) after the date I become eligible for state premium assistance for group coverage.
- If I decline life and/or disability coverage for any reason, my dependent(s) and I may enroll in the future as late entrants only if we provide satisfactory proof of insurability.

Please examine your options carefully before declining this coverage.

Signature of employee if declining coverage for self/dependents
X

Date

Social Security or member no.

6. SUBMIT PROOF OF COVERAGE

To comply with federal and state laws, proof of coverage, identified below in 6a and/or 6b, must accompany this application.

Acceptable forms of proof are:

1. Certificate of creditable coverage from prior carrier, or
2. Copy of ID card and copy of current payroll stub showing health coverage deduction, or
3. Copy of most recent health premium bill.
4. If you do not have a certificate, but do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have prior creditable coverage. You have the right to obtain a Certificate of Creditable Coverage from your prior plan. Please contact Anthem's customer service for assistance in obtaining such certificate or if you have questions regarding pre-existing conditions.

Please note that if you do not advise and provide proof of prior creditable coverage, you or your dependent(s) may be subject to a six-month pre-existing conditions exclusion

6a. OTHER COVERAGE

Please provide requested information if you or your dependent(s) have, or had in the past 63 days, any coverage other than the applied-for coverage. Use additional sheets if necessary.

Name of person covered (last name, first, M.I.)	TYPE (check one)		COVERAGE (check all that apply)			Name of carrier	STATUS (check)	DATES (if applicable)	
	Individual	Group	Health	Dental	Prescription		Have now and intend to keep	Start	End

6B. MEDICARE COVERAGE

Please provide information if you or your dependent(s) are currently receiving Medicare benefits.

Name (last name, first, M.I.)	Medicare no.	Effective date Part A	Part B	Part D	Reason for disability (if under age 65)

7. AUTHORIZATION – The following Authorization is applicable to ALL EMPLOYEES applying for coverage

General Notice of Pre-existing Condition Exclusion

The pre-existing condition exclusion does not apply to pregnancy; dependent children who are enrolled in the plan within 31 days after birth, adoption, or placement for adoption; or persons under 19 years old.

Your plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to your plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins.

This exclusion may last up to six-months if you are a late enrollee from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can have this exclusion period credited if you have had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to credit the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To have the six-month exclusion period credited based on your prior creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have prior creditable coverage. Please contact us if you need help demonstrating prior creditable coverage.

For all questions about the pre-existing condition exclusion and prior creditable coverage, call Anthem Blue Cross and Blue Shield at 800-922-4770 or 303-831-2098, or send them to Anthem Blue Cross and Blue Shield, P.O. Box 172405, Denver CO 80217-2405.

I hereby authorize that:

1. At the request of Anthem Blue Cross and Blue Shield any provider of heath 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 Blue Cross and Blue Shield, upon receiving this information may use it to review, investigate or revaluate 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 that are currently in effect or shall be in effect in the future for coverage for which I am applying.

If applying for health insurance coverage: I certify that I work at least 30 hours per week in the state of Nevada for the employer named in the application.

Name

Social Security or member no.

8. HEALTH STATEMENT – Please complete for yourself and all eligible dependent(s)

Use a separate sheet, if necessary. Privacy note: Anthem Blue Cross and Blue Shield will not give this confidential information to your employer, and you have the option of detaching this health statement page and submitting it to your employer in a sealed envelope. **All questions must be answered "Yes" or "No". INCOMPLETE APPLICATIONS WILL BE RETURNED FOR COMPLETION, WHICH MAY DELAY PROCESSING.**

Has any person listed on this application — had or consulted about, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions within the PAST 5 YEARS?

1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, hyperlipemia, arteriosclerosis, or any other disorder of the heart, blood or blood vessels? ☐ Yes ☐ No
2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver? ☐ Yes ☐ No
3. Cancer, cyst, or tumor? ☐ Yes ☐ No
4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction? ☐ Yes ☐ No
5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system? ☐ Yes ☐ No
   If epileptic, date of last seizure: ______ /______ /______
7. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? ☐ Yes ☐ No
8. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? ☐ Yes ☐ No
9. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems? ☐ Yes ☐ No
10. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? ☐ Yes ☐ No
11. Taken medicine as prescribed by a physician or other health practitioner? ☐ Yes ☐ No
12. a. Is any female to be covered currently pregnant? ☐ Yes ☐ No
    If yes, Due Date: ______ /______ /______ Expecting: ☐ Single ☐ Multiple ☐ Vaginal ☐ Caesarian
    b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? ☐ Yes ☐ No
13. Does anyone listed on this application use tobacco products? ☐ Yes ☐ No
14. Have you or your dependent(s) been hospitalized in the past 5 years? ☐ Yes ☐ No
15. Other conditions not stated above? ☐ Yes ☐ No
16. Will you be enrolling on the health plan? ☐ Yes ☐ No If yes, what is your Height ____ Weight ____ Date of Birth ____ /____ /____
17. Will your spouse or domestic partner be enrolling on the health plan? ☐ Yes ☐ No If yes, what is his/her Height ____ Weight ____ Date of Birth ____ /____ /____
18. Will you be enrolling dependent child(ren)? . ☐ Yes ☐ No If yes, how many? ____________

If you answered Yes to questions 1-15 for the past 5 years, please complete below (attach additional sheets if necessary)

Question no.: ____ Name of patient: ____________	Question no.: ____ Name of patient: ____________
Condition treated: ____________	Condition treated: ____________
Dates of treatment: Start ________ End ________	Dates of treatment: Start ________ End ________
Treatment rendered: ____________	Treatment rendered: ____________
Medication(s): ____________	Medication(s): ____________
Dosage(s) taken: ____________	Dosage(s) taken: ____________
Dates taken: Start ________ End ________	Dates taken: Start ________ End ________
check here if still taking ☐	check here if still taking ☐
Question no.: ____ Name of patient: ____________	Question no.: ____ Name of patient: ____________
Condition treated: ____________	Condition treated: ____________
Dates of treatment: Start ________ End ________	Dates of treatment: Start ________ End ________
Treatment rendered: ____________	Treatment rendered: ____________
Medication(s): ____________	Medication(s): ____________
Dosage(s) taken: ____________	Dosage(s) taken: ____________
Dates taken: Start ________ End ________	Dates taken: Start ________ End ________
check here if still taking ☐	check here if still taking ☐

Social Security or member no.

9. EMPLOYEE AUTHORIZATION, NOTICE AND REPRESENTATIONS FOR LIFE AND/OR DISABILITY COVERAGE

My signature on page 2 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 only be disclosed to outside parties without my authorization 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 the HIV virus or AIDS or 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, and 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 in 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 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 the 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.

Please keep this page for your records

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

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